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ABSTRACT

Virginia's Department of Education and Department of Health are concerned with the health of children and youth, and with the implementation of comprehensive school health programs. These guidelines provide a basis for developing a model school health program or for enriching an existing program, focusing on health services and school environment. Following a foreword noting that local autonomy, the presence of professional personnel, and availability of resources will influence the way the guidelines are adapted for local use, the sections of the guidelines are: (1) "Administrative Aspects of School Health," including interagency agreements and delineation of roles and responsibilities; (2) "School Health Environment," including mechanical operations and school food service; (3) "School Health Services," including special education medical assessment, school procedures for child protective services, and special health services; (4) "Risk Management," on legal liability issues and record-keeping; (5) "Students with Special Needs," including related public laws and sections of the Rehabilitation Act; (6) "Code of Virginia: Sections Relating to School Health," including attendance requirement, vision and hearing screening, and substance abuse; (7) "Evaluation of School Health Services," with specific guidelines; and (8) "Virginia School Health Forms," including certificate of religious exemption, scoliosis report, nutrition worksheet and referral form, and cumulative health record. Six appendices include recommendations from Virginia House and Senate, school nurse performance evaluations, and communicable disease reference chart. (WJC)

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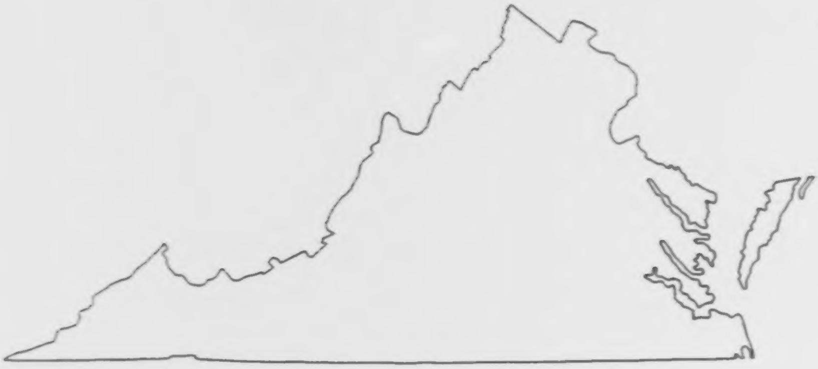
VIRGINIA SCHOOL HEALTH GUIDELINES

AUGUST 1992



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FORWARD

We are pleased to present the Virginia School Health Guidelines, a resource document for school and public health personnel. This publication, which is a major revision and expansion of a previous bulletin, is a cooperative project of the Virginia Department of Health and the Virginia Department of Education with assistance from local school divisions, local health departments, and the Virginia Pediatric Society.

The Departments of Education and Health are vitally concerned with the health of our children and youth, and with implementation of comprehensive school health programs. The guidelines provide a basis for the development of a model school health program or the enrichment of an existing program, focusing on health services and school environment. Local autonomy, the presence of professional personnel, and availability of resources will influence the way the guidelines are adapted for local use. We urge your careful review and consideration of the guidelines in establishing or enhancing a school health program to benefit the children and youth of Virginia.

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Sept. 10, 1992
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Special thanks is extended to Alice S. Linyear, M.D., M.P.H., who led this major undertaking. Her vision and leadership were instrumental in bringing the guidelines to fruition.

In addition, the Departments of Education and Health want to gratefully acknowledge members of the Committee for School Health Standards and other contributors for their expertise, time, and energy provided throughout this project. Please see Professional Credits for a complete list of names.

And finally, a special note of gratitude is extended to the Colorado Departments of Education and Health and to the South Carolina Department of Health and Environmental Control, whose respective publications, Colorado School Health Guidelines and School Health Program Manual, served as model resource documents. Many sections of the Virginia School Health Guidelines were adapted from each of these publications.

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PHILOSOPHY OF SCHOOL HEALTH

Good health is essential to effective living and learning. The school health program endeavors to promote health, which is defined by the World Health Organization as "...a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity."

Physical, emotional, mental, and social health problems affect children's ability to learn. A comprehensive school health program has a positive impact on the learning process by reducing health related barriers to learning. Furthermore, a comprehensive school health program enables students to be knowledgeable about healthy lifestyles, and encourages them to utilize the health care system to promote health and well-being.

Parents have the primary responsibility for the health of students. The community, which includes the schools, private medicine and dentistry, public health departments, voluntary agencies, and other civic groups, has a secondary responsibility. The school health program supplements and reinforces parents' efforts by encouraging students to utilize existing private and/or public health resources within the community to improve health status. Cooperation and collaboration among the school, community, and home are essential for successful school health programs.

Each local school division, with the assistance of its advisory board, should formulate its own philosophy and goals for a school health program. Consideration should be given to identified values, desired standards, local community needs, state and federal laws governing health requirements, and funding sources.

PREFACE

The Virginia School Health Guidelines was prepared as a cooperative effort of the Virginia Department of Education and the Virginia Department of Health to ensure quality school health services within the Commonwealth.

Overview

The purpose of the guidelines is to provide direction for school administrators, school nurses, and other health professionals in building comprehensive school health programs commensurate with local needs and resources. This document contains guidelines relevant to school health laws and requirements, committee recommendations, and standards by which the quality of the school health program can be measured. Emphasis is placed on the importance of administrative leadership and assistance by medical personnel, and on the need for clearly defined policies and responsibilities within the school health program.

The purpose of the guidelines is also to provide direction to the providers of direct services to students in the provision of first aid, health screening procedures, and special health services. The provision of services that are safe and of high quality minimizes the risk to student safety and health, as well as the liability risk to the school health services provider. The guidelines serve as a comprehensive school health reference source for all direct providers of school health services.

Focus

A comprehensive school health program provides health education (instruction) and health services in a healthy school environment. To be fully effective, the following basic components must be coordinated so that efforts in one area reinforce those in other areas: instruction, services, and environment (Reference: Council of Chief State School Officers. Beyond the Health Room. Washington D.C.: the Council, 1991). The guidelines focus on two of these components: school health services and a healthful school environment.

Sections

Most sections/subsections are divided into two components "Legal Basis" and "Recommendation." Each legal basis component describes or lists school and health laws related to that particular section/sub section. The recommendation component gives the Committee for

School Health Standards' recommendations for that section/subsection. The recommendations in the guidelines are based on standards, best practice, and/or research relevant to that section/sub section. Each school division needs to determine the applicability of the recommendations in light of local policies and available resources.

Section I introduces several key concepts, including characteristics of a comprehensive school health program, recommendations for developing a school health policy, requirements for establishing a school health advisory board, recommendations for establishing interagency agreements, roles of school health program personnel, and delineation/delegation of health and nursing care in a school setting.

Section II provides guidelines for ensuring a healthful school environment. Included are recommendations for establishing a school health clinic environment and facilitating a healthful physical environment.

Section III describes required and recommended student health services, including sample forms. Included is information on health and physical assessment requirements, immunization requirements, recommended and required screenings, nutrition information, school procedures for child protective services, and special health services.

Section IV contains information on relevant legal issues and mandates, including legal liability issues and recording guidelines.

Section V provides information on students with special needs. The section focuses on Public Law 94-142 (Education for All Handicapped Children Act), Public Law 101-476 (Individuals With Disabilities Education Act, formerly Public Law 99-457), and Public Law 93-112 Section 504 (Rehabilitation Act of 1973).

Section VI contains selected laws from the Code of Virginia relating to school health. For easy reference, the laws are grouped under the following subsections: attendance requirements, contagious diseases, child abuse and neglect, school health personnel, vision and hearing screening, advisory board, health care for minors/emergency care, safety and clean air, special education, substance abuse, and environment.

Section VII supplies a guide for evaluating of school health services. A sample evaluation guideline is included.

Section VIII contains school health forms used in Virginia.

Section IX contains the appendices. Each appendix is referred to in one or more sections of the guidelines.

References

The guidelines are based on the following sources of information:

- Committee on School Health, American Academy of Pediatrics. School Health: A Guide for Health Professionals. Elk Grove Village, Ill.: the Academy, 1987.
- Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.
- Report of the Secretary of Human Resources: The Health Needs of School-Age Children. Senate Document No. 22, Commonwealth of Virginia, 1987.
- Report of the Department of Education on: A Study On Ways to Encourage Local School Divisions to Recognize the Importance of School Nurses and the Feasibility of Establishing Standards for School Health Services. House Document No. 19, Commonwealth of Virginia, 1989.
- Standards for Accrediting Public Schools in Virginia. Commonwealth of Virginia, Department of Education, Richmond, Virginia, July 1988.
- School Health Program Manual. South Carolina Department of Health and Environmental Control, 1990.
- American Nurses' Association. Standards of School Nursing Practice. Kansas City, Mo.: the Association, 1983.
- Code of Virginia
- Other accepted professional standards, review of current literature in the field, and school and health related laws.

Specific references are included within the guidelines, when indicated.

Note

Although every effort has been made to make this edition of the guidelines as current as possible, changes are inevitable. Therefore, users of the Virginia School Health Guidelines are advised to confirm most recent forms, codes, and regulations.

ADMINISTRATIVE ASPECTS OF SCHOOL HEALTH

COMPREHENSIVE SCHOOL HEALTH PROGRAM

Purpose

The primary purpose of a school health program is to facilitate and promote optimal learning for students. The school has the responsibility and opportunity to promote good health among students and staff.

Goals

A school health program includes the following goals:

- To promote early identification and remediation of health problems and needs of students.
- To assist students to assume responsibility for their own health and to develop healthful attitudes and practices.
- To provide health education and counseling for students, school personnel, and parents.
- To provide health services and first aid for students and staff.
- To promote environmental safety and awareness of hazards.
- To maintain a liaison with health care providers and community health programs/agencies.
- To protect the health of students and staff by preventing the outbreak and spread of communicable diseases through enforcement of health laws and school policies.
- To promote school health services as part of the educational process.

Functions

To achieve these goals, a comprehensive school health program provides for the following functions:

- Delivery of health services to students and staff

- Provision of health instruction
- Provision of a safe and healthful school environment
- Child Advocacy

These functions are interrelated and complement each other. They may be developed, implemented, and evaluated independently. To achieve the desired outcome - students will grow to be healthier individuals, will learn better and have healthy lifestyles - each function must be thoroughly developed.

Reference:

Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

Standard

"Each local school board shall provide those support services which are necessary for the operation and maintenance of its public schools including, but not limited to, administration, instructional support, student attendance and health, operation and maintenance of the buildings, and management information systems."

Reference:

Standards of Quality For Public Schools in Virginia, Section 22.1-253.13:2 Standard 2. Board of Education, July 1990.

Legislative Reports

Health Needs of School-Age Children (Senate Document No. 22, 1987):

In response to Senate Joint Resolution Number 76, introduced during the 1986 Session of the General Assembly, the Secretary of Human Resources convened a task force composed of several members of the Virginia General Assembly and professionals in the fields of health, education, and human resources to study the health needs of school-age children. The task force focused its work on the following activities: 1) task force meetings, 2) survey of Virginia school health services, and 3) statewide community round table discussions.

The task force concluded that while the health of Virginia's school-age children has improved dramatically over the past decades, a look beyond the surface reveals that not all of Virginia's children share in this improvement. Based on its research and formal discussions, the task force recommended the establishment of twenty-three (23) recommendations to strengthen and coordinate school health services to meet effectively the health needs of school-age children in Virginia.

Please see Appendix A for a list of task force recommendations.

Reference:

Report of the Secretary of Human Resources: The Health Needs of School-Age Children. Senate Document No. 22, Commonwealth of Virginia, 1987.

Importance of School Nursing and Feasibility of Establishing Standards for School Health Services (House Document No. 19, 1989):

In response to House Joint Resolution Number 33, introduced during the 1988 Session of the General Assembly, the Departments of Education and Health convened a committee to study ways to encourage local school divisions to recognize the importance of school nurses and the feasibility of establishing standards for health services in the public schools in Virginia. The committee undertook the following activities: 1) presentations during committee meetings, 2) public forum on "The Importance of School Nursing and Health Needs of School-Age Children," and 3) distribution and analyses of survey and questionnaire.

The study committee concluded that the involvement of nurses within school settings and the establishment of standards for school health services are essential to the academic progress of Virginia's young people. Based on the committee's research and formal discussions, twelve (12) recommendations were offered as ways to encourage local school divisions to recognize the importance of school nurses and the feasibility of standards for school health services. Several of the recommendations pertaining to the importance of nurses in the school setting are also contained in the Report of the Secretary of Human Services: The Health Needs of School-Age Children, Senate Document No. 22, 1987 (described previously).

Please see Appendix B for a list of study committee recommendations.

Reference:

Report of the Department of Education on: A Study On Ways to Encourage Local School Divisions to Recognize the Importance of School Nurses and the Feasibility of Establishing Standards for School Health Services. House Document No. 19, Commonwealth of Virginia, 1989.

Model Program

The Model Comprehensive School Health Program summarized below is based on the best information available, including research studies and expert opinion; however, there is no empirical evidence that indicates this is the best model for Virginia or the only model that will work. Indeed, a number of models - as long as they are comprehensive and coordinated - could work.

This model program has eight elements, touching all aspects of the school experience and having the potential to significantly impact students' health knowledge, attitudes, and values. The eight elements are:

Element	Description
Health Education	A sequential instructional program covering all grades (pre-K through 12) and addressing the physical, mental, emotional, and social dimensions of health.
Health Services	Promotes the health of students and school personnel through prevention, early intervention, and remediation of specific health problems.
School Environment	Focuses on creating and maintaining physical and psychological well-being of student.
School & Community Agencies	Involves an integrated approach among health and education professionals in the school and community to provide and/or support improved school health programs.
Physical Education	Serves as a means for students to develop strength, coordination, and cardiovascular and respiratory efficiency, as well as for social development, stress reduction, and movement appreciation.
School Nutrition	Promotes good nutritional practices both within and outside the school setting.
Counseling	Provides broad-based prevention and intervention programs to promote the physical and psychological health of students and faculty.
Staff Wellness	Provides school personnel with the opportunity to take an active role in maintaining and improving their own physical and psychological health.

Other comprehensive school health programs may have more or fewer elements. What is essential, however, is that effort to provide services related to these eight elements are integrated and coordinated to provide the best possible health environment and experiences for students.

Reference:

A Report On Current Health Programs In The Public Schools of Virginia And The Efficacy And Appropriateness of Adopting A Comprehensive Approach to Health Education, A Response to House Joint Resolution No. 343, Virginia Department of Education, September 1991.

Student Health Issues

Please see Section Appendix F for Supts. Memo. No.61, June 12, 1992, Subject: Student Health.

FORMULATION OF SCHOOL HEALTH POLICY

Legal Basis

Standards for Accrediting Public Schools in Virginia. Commonwealth of Virginia, Department of Education, Richmond, Virginia, July 1988.

Standards of Quality for Public Schools in Virginia. Board of Education, July 1990.

Code of Virginia Section 22.1-275.1. School health advisory board.

Excerpt:

See Section VI. of this document, Code of Virginia: Advisory Board

Recommendation

Each school division should carefully plan, develop, and evaluate its school health policy in an effort to provide comprehensive school health services and to comply with school accreditation requirements.

The formulation of school health policy should support the educational goals and objectives of the local school division and enhance the education of all students.

School health policy should reflect local school health needs and include broad multidisciplinary expertise and knowledge regarding health issues. The purpose of the School Health Advisory Board is to assist with the development of a school health policy in the school division.

The participation of the school nurse and/or the school nurse coordinator is vital in the development of school health policy. As a child and adolescent health expert who also has knowledge of the educational system, the school nurse has a unique and critical contribution to make in the development of school health policy.

SCHOOL HEALTH ADVISORY BOARD

Legal Basis

Code of Virginia Section 22.1-275.1. School health advisory board.

Excerpt:

"Each school board shall establish a school health advisory board of no more than twenty members which shall consist of broad-based community representation including, but not limited to, parents, students, health professionals, educators and others. The school health advisory board shall assist with the development of health policy in the school division and the evaluation of the status of school health, health education, the school environment, and health services.

The school health advisory board shall hold meetings at least semi-annually and shall annually report on the status and needs of student health in the school division to any relevant school, the school board, the Virginia Department of Health, and the Virginia Department of Education."

SUPTS. MEMO. No. 137, June 19, 1992, Subject: School Health Education Advisory Board

Excerpt:

"The 1992 General Assembly amended and reenacted § 22.1 - 275.1 to require each school division to have a school health advisory board. The advisory board should be organized to advise school divisions about the development and implementation of school health programs, including health instruction, the school environment and health services.

The school health advisory board should be organized to include no more than twenty (20) members, with a broad base of representation including parents, students, health professionals and educators. In addition, the board may be organized to include representatives from community agencies, the local school board, business and industry, child advocacy groups, volunteer health agencies, the school division staff, and institutions of higher education. Each advisory board is required to meet at least semi-annually and to provide an annual report on the status and needs of student health in the school division to any relevant school, the school board, the Virginia Department of Health and the Virginia Department of Education."

Recommendation

Composition in each school division:

- Elementary Principal
- Secondary Principal
- Elementary Teacher
- Secondary Teacher (preferably health)
- Parent PTA Representative
- Parent of a Medically Fragile Child
- Parent of a Special Education Student
- Nurse (school nurse, where available)
- Representative of the Local Health Department
- Two Primary Care Physicians (pediatrics, family practice)
- Pupil Medical Director (if there is one)
- Guidance Counselor
- Member of the Business Community
- High School Student
- Dentist
- Registered Dietitian (if not available, nutritionist or home economics teacher)
- Child/Adolescent Psychologist or Psychiatrist

INTERAGENCY AGREEMENTS

Legal Basis

Regulations and laws governing practices in certain state agencies require that they work collaboratively or enter into interagency agreements to provide services to children and youth.

Recommendation

There should be an agreement among agencies that affects the health and well-being of children attending school. This agreement could include departments of health, social services, mental health, youth services, fire, police, juvenile court, and public schools. The agreement should be written and reviewed annually and updated as necessary.

Factors to be considered in writing an interagency agreement:

- Prologue

  Introduces the need for the interagency agreement.

- Agreement

  - Provides for the names of the agencies, terms or beginning and ending dates, and renewal or evaluation criteria.
  - Gives definitions of key words and phrases contained in the agreement.
  - Describes the flow of communication between the agencies, including but not limited to the following: name of involved individual, when appropriate; description of the situation; and needs, other potentially affected individuals or groups of individuals, and location (home, school, etc.) of affected individual or group of individuals.

- Epilogue

  Contains information related to the individual rights of a client(s) to confidentiality of information and written consent to release information to other agencies, and other information related to decisions regarding the implementation of the agreement.

A locale may want to secure a sample interagency agreement for guidance.

SCHOOL HEALTH PROGRAM PERSONNEL

Legal Basis

Personnel involved in implementing a school health program are not mandated; however, the services must be provided in accordance with the following:

- Code of Virginia
- Standards for Accrediting Public Schools in Virginia. Commonwealth of Virginia, Department of Education, July 1988.
- Standards of Quality for Public Schools in Virginia. Board of Education, July 1990.

Recommendation

School Health Team

The basic school health team consists of the student's parent, primary care physician, school physician or public health medical director, and school nurse. A school nurse practitioner functioning in an expanded role may also be a member of the school health team per school division policy. Ideally this group will collaborate with administrators, teachers, guidance counselors, occupational therapists, physical therapists, social workers, psychologists, educational diagnosticians, food services, dentists, court services, legal services, and child welfare services.

The school health team recognizes that parents or guardians have the basic responsibility for the health of their children. School health services supplement, rather than substitute for, parental care and concern for the health of the student. Parents are to be advised of health problems, encouraged to secure needed medical or dental care, and made aware of various private and public community resources available to them.

Interdisciplinary Team

The intervention of an interdisciplinary team is the ideal method to be used in solving problems of a student with complex medical/social/emotional needs. The team works in collaboration to develop a comprehensive plan to meet the needs of each student with multiple problems. The individual disciplines represented on the team will vary according to the problems of the student.

The appropriate lead member of the interdisciplinary team should be based upon the student's primary need. Interdisciplinary team membership may vary among school divisions; smaller school systems are more likely to have personnel who are assigned multiple roles. The key to the interdisciplinary approach is not so much the specific disciplines represented on the team, but the holistic approach to problem solving and to meeting the needs of each student.

The activities of school health staff may overlap with those of other school personnel. For example, children with social and emotional problems are the concern of school guidance counselors, social workers, psychologists, mental health workers, and special education teachers, as well as of the school physician and nurse. Coordination of efforts is necessary to prevent duplication of services and to ensure a holistic approach in meeting the student's health needs. Coordination of interventions by the interdisciplinary team is the ideal method to be used in solving problems of a student with complex medical/social/emotional needs.

For an interdisciplinary team to function cohesively, each member must understand the role of the other members of the team. The following guidelines contain recommended functions and responsibilities of various team members. The information contained under staff personnel is not intended to be a complete position description.

Reference:

Committee on School Health, American Academy of Pediatrics. School Health: A Guide for Health Professionals. Elk Grove, Ill.: the Academy, 1987, p. 8.

Functions and Responsibilities of School Health Program Personnel

The following subsections provide guidelines on the roles of each of the following school health program personnel:

- Parent
- School Administrator
- Physician
- School Health Nurse
- School Health Coordinator
- School Health Nurse Practitioner

- School Social Worker/Visiting Teacher
- School Psychologist
- Educational Diagnostician
- Dental Personnel
- School Health Paraprofessional
- School Health Volunteer

Parent

Parents or guardians have the primary responsibility for the health and well-being of their children; it is not the intent or desire of the school to relieve parents of that responsibility. School health services supplement rather than substitute for parental care and concern for the health of the student. Parents are to be advised of health problems and encouraged to secure needed medical or dental care.

The health and emotional well-being of school children may also involve a number of outside professional agencies and institutions, such as health, social services, counseling, and law enforcement organizations. Efforts of these groups are best coordinated by frequent parent contact and an emphasis on the parents' role in decision-making.

References:

American Academy of Pediatrics. School Health: A Guide for Health Professionals. Elk Grove, Ill.: the Academy, 1987, p.8.

Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

School Administrator

The school administrator is responsible for the quality and quantity of health services, health education, and to see that a healthful environment exists within the school building and grounds. Provision of these services requires liaison within the school community with students, parents, community physicians, and the local health department to insure a healthful learning environment for each student. The school administrator is knowledgeable of state and school division regulations concerning maintenance of student health records, processes health and accident reports, and is familiar with laws and regulations affecting school/student health issues. Functions of the school administrator may include: selecting, coordinating, and evaluating qualified health services staff; providing and maintaining facilities such as the health services office and health education classrooms; and initiating meetings to make decisions regarding the health of students and staff.

Physician

Primary Care Provider

"The most valuable role of the physician as primary care provider in a school program is that of general resource and liaison between the child, the family, and school personnel. By interpreting the health problems of a student for school personnel, the physician helps the staff to modify the student's program as needed. Conversely, the school helps the primary care provider by providing pertinent information, and by reporting observations about the student's physical and emotional behavior. In certain circumstances, the school can help the physician manage some aspects of health problems, such as psychosocial disorders, chronic disease, and physical disabilities."

Reference:

American Academy of Pediatrics. School Health: A Guide for Health Professionals. Elk Grove, Ill.: the Academy, 1987, p. 9.

School Health Physician

The role of the school physician is to serve in the capacity of consulting medical director to provide medical evaluations, consultation, and support to nursing personnel. The duties of the school physician are to provide consultation to the school health program, provide medical evaluations where appropriate, and maintain two-way communication between the school and the student's primary care physician. The school physician may be employed by a single school division or by a group of school divisions.

Medical Director of the Local Health Department

The role of the medical director of the local health department is to serve as a consultant and/or advisor to the local school division regarding school health laws, immunization regulations, control of communicable diseases, and enforcement of environmental laws and regulations. He/she may also serve as advisor for medical concerns related to medically fragile/unstable students, special education placement, and issues related to Section 504 of the Rehabilitation Act.

School Health Nurse

Minimum Qualifications:

- Current license to practice as a registered professional nurse in the Commonwealth of Virginia
- Experience with child and adolescent health care
- Current certification in cardiopulmonary resuscitation (CPR)

Desirable Qualifications:

- Bachelor's degree in nursing, education, or public health
- Current knowledge in emergency care, including first aid
- Experience and/or education in the following areas:
  - Organization, administration, and operation of public schools
  - Legal provisions impacting upon school health services and child welfare
  - Human growth and development, with emphasis on childhood and adolescence
  - Psychology of personality and mental health
  - Psychology of human relations in school and community
  - Psychology of exceptional children
  - Social problems related to ethnic, cultural, and economic factors
  - Poverty and child welfare
  - Health assessment

Responsibilities:

- Functioning as a contributing member of the school staff in all aspects of the school program.
- Functioning as a contributing member of the school health team in all aspects of the school health program.
- Assessing and evaluating the total health and developmental status of students through nursing assessments and the use of appropriate evaluation techniques (including nursing intervention for acute illness, injury, and emotional disturbance).
- Providing consultation and referral to students' primary medical care providers for evaluation with treatment and follow-up, if necessary, for suspected health problems.
- Reporting compliance with state laws requiring immunization and exclusion of students with contagious diseases.
- Supporting with nursing knowledge and skills school attendance for children who must use medication in the treatment of illness or chronic disabilities.
- Assisting students, parents, and teachers to obtain optimum wellness by stimulating behavior through individual and group health counseling.
- Assisting in the appropriate placement of students with exceptional needs.
- Assisting students, parents, and teachers to adapt to chronic health problems of students.
- Serving as a child advocate.
- Encouraging a well-nourished school population.
- Protecting the well-being of students.
- Setting and maintaining standards of emergency care to minimize the effects of accidents and illness in the school.
- Encouraging each student to be a health-educated person and a knowledgeable health consumer.
- Assuring that the health needs of the school population are considered in the community's overall health planning.

- Improving school nursing and school health through research and evaluation.

Reference:

Adapted from: Weber, Helen: Guidelines for a Model School Nurse Services Program. For the National Association of School Nurses, an affiliate of the National Education Association.

Evaluation:

- Performed annually or per school board policy.
- Evaluated jointly by building administrator for administrative policies and clinical supervisor (ideally the school health coordinator) for clinical skills.

Please see Appendix C-1 and Appendix C-2 for sample evaluation tools.

Standard

The standards of professional nursing practice presented below are taken directly from the American Nurses' Association's Standards of School Nursing Practice, 1983. The standards reflect the current state of knowledge in the field and are therefore provisional, dynamic, and subject to testing and subsequent change. Since standards represent agreed-upon levels of quality in practice, they have been developed to characterize, measure, and provide guidance in achieving excellence in care.

- The school nurse applies appropriate theory as basis for decision making in nursing practice.
- The school nurse establishes and maintains a comprehensive school health program.
- The nursing process includes individualized health plans which are developed by the school nurse.
  - The school nurse collects information about the health and developmental status of the student in a systematic and continuous manner.
  - The nurse uses data collected about the health and educational status of the student to determine a nursing diagnosis.

  - ○ The nurse develops a nursing care plan with specific goals and interventions delineating school nursing actions unique to student needs.

  - ○ The nurse intervenes as guided by the nursing care plan to implement nursing actions that promote, maintain, or restore health, prevent illness, and effect rehabilitation.

  - ○ The nurse assesses student responses to nursing actions in order to revise the data base, nursing diagnoses, and nursing care plan and to determine progress made toward goal achievement.

- The school nurse collaborates with other professionals in assessing, planning, implementing, and evaluating programs and other school health activities.

- The nurse assists students, families, and groups to achieve optimal levels of wellness through health education.

- The school nurse participates in peer review and other means of evaluation to assure quality of nursing care provided for students. The nurse assumes responsibility for continuing education and professional development and contributes to the professional growth of others.

- The school nurse participates with other key members of the community responsible for assessing, planning, implementing, and evaluating school health services and community services that include the broad continuum of promotion of primary, secondary, and tertiary prevention.

- The school nurse contributes to nursing and school health through innovations in theory and practice and participation in research.

Determination of School Nurse Staffing Patterns

The establishment of school nurse staffing patterns in school settings varies across the United States, dependent upon identified needs of students and available resources. In general, these staffing decisions are made based on one or a combination of the following criteria:

- Numbers of students in an area of responsibility

- Population density

- Numbers of handicapped students

- Health services and education to be provided to all students or a portion of students
- Federal, state, and local funding
- Federal, state, and local regulations
- Identified health care delivery personnel (public health department, consultant services).

The following ratios are presented as general guidelines:

- 1:750 in general school populations
- 1:225 in mainstreamed populations
- 1:125 in severely/profoundly handicapped populations

Reference:

American Nurses' Association. Standards of School Nursing Practice. Kansas City, Mo.: the Association, 1983.

School Health Coordinator

Minimum Qualifications:

- The qualifications as listed under school health nurse
- Bachelor's degree with emphasis on nursing, education, or public health
- Minimum of three years experience in school nursing
- Experience in program administration

Desirable Qualifications:

- Experience in personnel management
- Master's degree
- Certification by a national board of school nurse certification organization

Responsibilities:

- Developing and coordinating a system-wide health services program for students and staff including all the areas of responsibilities as listed under the School Health Nurse sub section.
- Hiring, educating, and supervising, including on-site visits, and evaluating the school health personnel.
- Developing written health policies for the school system.
- Serving as a liaison among the professional medical community, the various departments within the school, parents, administrators, students, and the health service providers.
- Interpreting state health regulations and developing programs to comply with them.
- Assisting and/or teaching health-related topics in the classroom.

Evaluation:

- Performed annually or as required by school board policy.

School Health Nurse Practitioner

Minimum Qualifications:

- Meet minimum qualifications as a school health nurse
- Certification as a nurse practitioner
- Experience in child and adolescent primary health care
- Bachelor's degree in nursing, education, or public health

Desirable Qualifications:

- Master's degree in primary health care nurse specialist/practitioner with emphasis in pediatric, family, or school health
- Experience and/or education in the areas of school law and school health

Responsibilities:

- Must report to licensed physician preceptor.
- Conducting health and development histories.
- Conducting and recording health appraisals including physical assessments and development evaluations from the newborn period through adolescence.
- Differentiating between normal findings and those that require consultation and/or referral.
- Assessing the child's and family's psychosocial, emotional, spiritual, cultural, physiologic and environmental needs and priorities.
- Diagnosing children with common acute conditions, illnesses, or minor trauma within legally accepted protocols and Virginia Nurse Practice Act.
- Formulating health plans that emphasize self-care responsibility through the participation of the child, family, physician, and other health professionals.

- Determining those cases that require consultation and/or referral with the pediatrician or other professional of the health care team.
- Encouraging health promotion and providing preventive health care that includes immunizations, anticipatory guidance, health education, and counseling.
- Treating children with common acute conditions, illnesses, or minor trauma within legally accepted protocols and Virginia Nurse Practice Act or in collaboration with the physician.
- Collaborating with pediatricians or other health professionals in the health care of children with chronic illnesses.
- Counseling children and families as needed.
- Identifying resources and coordinating referrals for children and families requiring further evaluation.
- Interacting with appropriate community agencies to facilitate implementation of health care plan.
- Analyzing results of health care plans.
- Modifying health care plans as indicated.
- Implementing and participating in appropriate follow-up.

Reference:

The above responsibilities are based on the scope of practice for the National Association of Pediatric Nurse Associates and Practitioners.

Evaluation:

- Performed annually or as required by school board policy.
- Evaluated jointly by licensed physician preceptor and immediate supervisor.

School Social Worker/Visiting Teacher

Qualifications:

The school social worker and the visiting teacher are trained at the master's level to provide the responsibilities stated below. There is a difference, however, in the nature of their training. The school social worker has completed primary course work in a school of social work, and the visiting teacher's experience is in the area of education. Generally their qualifications are as follows:

- School Social Worker
  - Master of Social Work with specific graduate courses in education
  - One year of full-time internship supervised by a qualified school social worker
- Visiting Teacher
  - Master's degree with specific graduate courses in education, social work, or related areas
  - One year of successful teaching experience

Responsibilities:

School social workers and visiting teachers are professionals who are often involved in identifying health needs and in referring students and families to health resources. Their primary responsibilities are as follows:

- Assisting families in understanding their children's educational needs and in taking advantage of appropriate school and community services.
- Providing extensive outreach services, including home visits to students and parents to help resolve school-related problems and conflicts.
- Helping students overcome barriers to school attendance.
- Serving as a primary school liaison between community agencies and other professionals serving students and their families.

- Providing sociocultural assessments of students being evaluated for special education services.
- Conducting a variety of parent education activities geared to supporting and strengthening the school-parent relationship.
- Retrieving dropouts, linking them with needed educational and community services.
- Serving on multidisciplinary child study committees in each school.
- Consulting with teachers to help them better understand and work with individual students.
- Collaborating with teachers, administrators, and other school personnel to provide effective instructional and support services to marginally performing or high risk students.
- Contributing to the development and implementation of individualized education programs (IEP's). School social work services may be required, as in an IEP related service, to help a handicapped child benefit from special education.
- Assisting administrators in resolving disciplinary problems.
- Serving on task forces and committees that develop programs and practices, particularly those affecting at risk students.
- Serving on school crisis teams.
- Conducting a variety of inservice training activities on such topics as effective communication with parents, cultural and linguistic differences in families, barriers to attendance, children who are withdrawn or disruptive, classroom management, and social skills.
- Providing case management in especially complex or difficult situations.
- Conducting studies of problems and issues affecting students.
- Helping the community identify and develop resources to better serve the needs of troubled students.
- Representing school-age children.

- Maintaining ongoing communication between schools and community agencies to facilitate interagency collaboration.

School Psychologist

Minimum Qualifications:

- 60 semester hour graduate program in school psychology culminating in a master's degree or educational specialist degree (Ed.S.)
- One year full-time internship under the supervision of a qualified psychologist
- Substantial preparation in the following areas:
    - Psychological foundations
    - Educational foundations
    - Assessment and intervention
    - Statistics and research design
    - Professional school psychology
- Postgraduate professional certificate with endorsement in school psychology through the Virginia Department of Education

Desirable Qualifications:

- Doctorate degree in school psychology
- Advanced training in administration, supervision, and consultation

Responsibilities:

- Administering psychological and educational evaluations of students as part of the formal assessment of cognitive, academic, and emotional/social functioning.
- Consulting with school staff, parents, and community professionals in the amelioration and prevention of educationally related problems.
- Counseling with individuals and small groups to develop effective problem-solving skills.

- Developing special intervention programs, curriculum and teaching strategies, and behavior management techniques.

- Providing inservice training on effective practices to school staff, parents, professional organizations, and community agencies.

- Participating on school-based, problem solving committees such as child study committees, eligibility committees, and individual educational programs and crisis intervention teams.

- Collecting and interpreting information and data for program evaluation, research, and planning purposes.

Educational Diagnostician

The educational diagnostician conducts educational assessments and generates an educational report to be used as one of the components in determining a student's original eligibility for special education services.

Dental Personnel: Dentist, Dental Hygienist, Dental Assistant

Dentist

Minimum Qualifications:

- Meet qualifications as a dentist licensed in Virginia

Desirable Qualifications:

- Experience as a pediatric dentist
- Experience and education in planning, implementing, and evaluating a community dental health program
- Current certification in first aid and cardiopulmonary resuscitation (CPR)

Responsibilities:

- Securing medical and dental histories.
- Securing parental permission for dental treatment.
- Providing dental screenings.
- Formulating treatment plans appropriate for primary and preventive dental care.
- Supervising dental auxiliaries in the delegated dental treatment.
- Providing primary dental care for eligible pre-school and school-age children.
- Planning appropriate preventive dental measures for school-age children.
- Encouraging health promotion for improved oral health within the school and community.
- Serving as a resource for the teachers and parents on dental topics.
- Identifying resources and coordinating referrals for children if needed.

- Interacting with appropriate community agencies in meeting program goals.

Dental Hygienist

Minimum Qualifications:

- Meet qualifications as a dental hygienist licensed in Virginia

Desirable Qualifications:

- Experience with pediatric patients
- Experience and education in dental health education programs and program planning
- Current certification in first aid and cardiopulmonary resuscitation (CPR)

Responsibilities:

- Providing preventive dental treatment as delegated by the dentist.
- Planning and implementing dental health educational sessions appropriate for classroom activities.
- Encouraging health promotion for improved oral health within the school and community.
- Providing dental screenings.
- Serving as a resource for teachers and parents on dental topics.
- Participating in community health fairs.

Dental Assistant

Minimum Qualifications:

- Training equivalent to that required by the Virginia State Board of Dental Examiners for dental assistants (assisting skills may be learned on the job if no intra-oral procedures are performed)

Desirable Qualifications:

- Certification as a dental assistant
- Experience with pediatric patients
- Current certification in first aid and cardiopulmonary resuscitation (CPR)

Responsibilities:

- Assisting the dentist during patient appointments utilizing four-handed dentistry.
- Encouraging health promotion for improved oral health within the school and community.
- Participating in community health fairs.
- Performing other duties as delegated by the dentist.

School Health Paraprofessional

Definition:

- Auxiliary personnel employed to assist registered professional nurse
- Supervised by the registered nurse in health-related areas

Minimum Qualifications:

- High school diploma
- Current certification in first aid and cardiopulmonary resuscitation (CPR)

Desirable Qualifications:

- Post high school education
- Office management skills such as typing and filing
- Experience in the care of school-age child
- Certification as a nursing assistant
- Licensed Practical Nurse

Responsibilities:

- Maintaining confidentiality on student information.
- Attending to health needs of students - following guidelines contained within the First Aid Guide For School Emergencies flipbook.
- Assisting with recommended and state-mandated screenings.
- Administering medications and treatments if provided for in the policy of the appropriate authority (i.e. the local school division or local public health department).

- Maintaining accurate student records and daily logs.
- Collecting data for state required reports.
- Reporting major health concerns to the supervising nurse and building administrator within appropriate time lines.
- Initiating and distributing incident and accident reports per local school division policy.
- Communicating with parents on health-related issues.
- Maintaining a clean, orderly, and attractive health office.
- Performing other tasks as assigned by the supervising nurse and/or building administrator.
- Attends ongoing inservice education programs.

Evaluation:

- Performed annually by supervising nurse and building administrator

School Health Volunteer

School health volunteers should be selected and function according to local school division policy. Volunteers should not administer medications or perform treatments unless specifically covered by local school board policy. In addition, they should not have access to confidential student records.

Reference:

Management of the Student's Scholastic Record in the Public Schools of Virginia. Virginia Department of Education, 1989.

DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATION SETTING

Legal Basis

Code of Virginia Section 54.1-3000. Definitions.

Excerpt:

Registered Nurse

" 'Professional nurse,' 'registered nurse' or 'registered professional nurse' means a person who is licensed under the provisions of this chapter to practice professional nursing as defined in this section. Such a licensee shall be empowered to provide professional services without compensation, to promote health and to teach health to individuals and groups. The abbreviation 'R.N.' shall stand for such terms."

" 'Professional nursing,' 'registered nursing' or 'registered professional nursing' means the performance for compensation of any nursing acts in the observation, care and counsel of individuals or groups who are ill, injured or experiencing changes in normal health processes or the maintenance of health; in the prevention of illness or disease; in the supervision and teaching of those who are or will be involved in nursing care; or the administration of medications and treatments as prescribed by any person authorized by law to prescribe such medications and treatment. Professional nursing, registered nursing and registered professional nursing require specialized education, judgement, and skill based upon knowledge and application of principles from the biological, physical, social, behavioral and nursing sciences."

Licensed Practical Nurse

" 'Practical nurse' or 'licensed practical nurse' means a person who is licensed under the provisions of this chapter to practice practical nursing as defined in this section. Such a licensee shall be empowered to provide nursing services without compensation. The abbreviation 'L.P.N.' shall stand for such terms."

" 'Practical nursing' or 'licensed practical nursing' means the performance for compensation of selected nursing acts in the care of individuals or groups who are ill, injured, or experiencing changes in normal health processes; in the maintenance of health; in the prevention of illness or disease; or, subject to such regulations as the Board may promulgate, in the teaching of those who are or will be nurse aides. Practical nursing or licensed practical nursing requires knowledge, judgment and skill in nursing procedures gained through prescribed education. Practical nursing or licensed practical nursing is performed under the direction or supervision of a licensed medical practitioner, a professional nurse, registered nurse or registered professional nurse or other licensed health professional authorized by regulations of the Board."

Recommendation

Advances in health care technology and procedures have resulted in increased numbers of children with special health care needs in the school setting. The trends toward out-patient and home-based treatments, federal mandates for mainstreaming special education students, plus parental expectations have all reinforced the need for school systems to clearly define roles and responsibilities in addressing the specialized health care needs of these children.

Specialized health care procedures should be performed by qualified personnel who have received child specific training as defined by the child's primary health care provider(s) and the child's family. Every child who has a special health care need requiring nursing care, intervention, and/or supervision should have a nursing care plan written by a nurse.

The National Joint Task Force for the Management of Children with Special Health Needs with membership from the American Federation of Teachers, the Council for Exceptional Children, the National Association of School Nurses, and the National Education Association developed the matrix, "Guidelines For The Delineation Of Roles and Responsibilities For The Safe Delivery of Specialized Health Care in The Educational Setting" (please see matrix at the end of this section). Many of the special health care procedures that some children may need in the educational setting are regulated by professional standards of practice. The matrix delineates the persons qualified to perform specific procedures, who should perform them, and the circumstances under which these persons would be deemed qualified. The term "qualified" assumes that the individual has received appropriate training and has been certified as competent to perform the procedure by a registered nurse or physician.

Following the matrix is the National Association of State School Nurse Consultants, Inc. statement "Delegation of Nursing Care in a School Setting."

Reference

Joint Task Force for the Management of Children with Special Health Care Needs. Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Specialized Health Care in the Educational Setting. Reston, Virginia, May 1, 1990.

GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING *

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL[1]	PARA PROFESSIONALS[2]	OTHERS[3]
1.0 ACTIVITIES OF DAILY LIVING							
1.1 Toileting/Diapering		A	A	A	A	[✓ A]	A
1.2 Bowel/Bladder Training (Toilet Training)		A	A	[✓ A]	A	S	S
1.3 Dental Hygiene		A	A	A	A	S	S
1.4 Oral Hygiene		A	A	[✓ A]	A	S	S
1.5 Lifting/Positioning		A	A	[✓ A]	A	S	S
1.6 Feeding							
1.6.1 Nutrition Assessment		A	X	X	N	X	X
1.6.2 Oral-Motor Assessment		X	X	X	[✓ SP/TH]	X	X
1.6.3 Oral Feeding		A	A	A	A	[✓ S]	S
1.6.4 Naso-Gastric Feeding	•	[✓ A]	[✓ S]	X	X	[✓ S/HA]	X
1.6.5 Monitoring of Naso-Gastric Feeding		A	S	S	S	S	X
1.6.6 Gastrostomy Feeding	•	[✓ A]	[✓ S]	X	X	[✓ S/HA]	X
1.6.7 Monitoring of Gastrostomy Feeding		A	S	S	S	S	X
1.6.8 Jejunostomy Tube Feeding	•	[✓ A]	[✓ S]	X	X	X	X
1.6.9 Total Parenteral Feeding (Intravenous)	•	[✓ A]	[✓ S]	X	X	X	X
1.6.10 Monitoring of Parenteral Feeding		A	S	S	S	S	X

DEFINITION OF SYMBOLS

A	Qualified to perform task, not in conflict with professional standards
S	Qualified to perform task with RN supervision and inservice education
EM	In emergencies, if properly trained, and if designated professional is not available
X	Should not perform
N	Nutritionist only
TH	Occupational or physical therapist only
SP	Speech/language Pathologist only
○	Person who should be designated to perform task
HA	Health Aide only

[1] Related Services include N, TH, and SP.

[2] Paraprofessionals include teacher aides, health aides, uncertified teaching personnel.

[3] Others include secretaries, bus drivers, cafeteria workers, custodians.

* DELINEATION OF RESPONSIBILITIES MUST ADHERE TO EACH STATE NURSE PRACTICE ACT.

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GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING *

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL¹	PARA PROFESSIONALS²	OTHERS³
1.6.11 Naso-Gastric Tube Insertion	•	(A)	(S)	X	X	X	X
1.6.12 Naso-Gastric Tube Removal	•	(A)	(S)	EM	EM	EM/HA	X
1.6.13 Gastrostomy Tube Reinsertion	•	(A)	(S)	X	X	X	X
2.0 CATHETERIZATION							
2.1 Clean Intermittent Catheterization	•	(A)	(S)	X	X	S/HA	X
2.2 Sterile Catheterization	•	(A)	(S)	X	X	X	X
2.3 Crede	•	A	S	S	S	(S/HA)	S
2.4 External Catheter	•	(A)	(A)	S	S	(S/HA)	X
2.5 Care of Indwelling Catheter (Not Irrigation)	•	(A)	(S)	S	S	(S/HA)	X
3.0 MEDICAL SUPPORT SYSTEMS							
3.1 Ventricular Peritoneal Shunt							
3.1.1 Pumping	•	(EM)	(EM)	X	X	X	X
3.1.2 Monitoring	•	(A)	S	S	S	S	X
3.2 Mechanical Ventilator							
3.2.1 Monitoring	•	(A)	(S)	EM	EM	S/HA	X
3.2.2 Adjustment of Ventilator	•	X	X	X	X	X	X
3.2.3 Equipment Failure	•	(A)	(S)	EM	EM	EM	EM

DEFINITION OF SYMBOLS

A Qualified to perform task, not in conflict with professional standards
S Qualified to perform task with RN supervision and inservice education
EM In emergencies, if properly trained, and if designated professional is not available
X Should not perform

N Nutritionist only
TH Occupational or physical therapist only
SP Speech/language Pathologist only
○ Person who should be designated to perform task

HA Health Aide only

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1 Related Services include N, TH, and SP.

2 Paraprofessionals include teacher aides, health aides, uncertified teaching personnel.

3 Others include secretaries, bus drivers, cafeteria workers, custodians.

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GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING *

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL[1]	PARA PROFESSIONALS[2]	OTHERS[3]
3.3 Oxygen							
3.3.1 Intermittent	•	Ⓐ	Ⓢ	EM	EM	EM	X
3.3.2 Continuous (Monitoring)	•	A	S	S	S	S	S
3.4 Hickman/Broviac/IVAC/IMED	•	Ⓐ	Ⓢ	X	X	X	X
3.5 Peritoneal Dialysis	•	Ⓐ	Ⓢ	X	X	X	X
3.6 Apnea Monitor	•	A	S	S	S	S/HA	X

4.0 MEDICATIONS

Medications may be given by LPN's and Health Aides only where the Nurse Practice Act of the individual state allows such practice, and under the specific guidelines of that nurse practice act.

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL[1]	PARA PROFESSIONALS[2]	OTHERS[3]
4.1 Oral	•	Ⓐ	Ⓢ	X	X	S/HA	X
4.2 Injection	•	Ⓐ	Ⓢ	X	X	X	X
4.3 Epi-Pen Allergy Kit	•	Ⓐ	Ⓢ	EM	EM	EM	EM
4.4 Inhalation	•	Ⓐ	Ⓢ	EM	EM	EM/HA	EM
4.5 Rectal	•	Ⓐ	Ⓢ	X	X	EM/HA	X
4.6 Bladder Installation	•	Ⓐ	Ⓢ	X	X	X	X
4.7 Eye/Ear Drops	•	Ⓐ	Ⓢ	X	X	S/HA	X

DEFINITION OF SYMBOLS

A Qualified to perform task, not in conflict with professional standards
S Qualified to perform task with RN supervision and inservice education
EM In emergencies, if properly trained, and if designated professional is not available
X Should not perform
N Nutritionist only
TH Occupational or physical therapist only
SP Speech/language Pathologist only
○ Person who should be designated to perform task
HA Health Aide only

[1] Related Services include N, TH, and SP.
[2] Paraprofessionals include teacher aides, health aides, uncertified teaching personnel
[3] Others include secretaries, bus drivers, cafeteria workers, custodians

* DELINEATION OF RESPONSIBILITIES MUST ADHERE TO EACH STATE NURSE PRACTICE ACT.

GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING *

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL[1]	PARA PROFESSIONALS[2]	OTHERS[3]
4.8 Topical	•	Ⓐ	Ⓢ	X	X	S/HA	X
4.9 Per Nasogastric Tube	•	Ⓐ	Ⓢ	X	X	S/HA	X
4.10 Per Gastrostomy Tube	•	Ⓐ	Ⓢ	X	X	S/HA	X
4.11 Intravenous	•	Ⓐ	Ⓢ	X	X	X	X
4.12 Spirometer	•	Ⓐ	Ⓢ	X	X	S/HA	X
5.0 OSTOMIES							
5.1 Ostomy Care	•	Ⓐ	Ⓢ	EM	EM	EM	X
5.2 Ostomy Irrigation	•	Ⓐ	Ⓢ	X	X	X	X
6.0 RESPIRATORY ASSISTANCE							
6.1 Postural Drainage	•	Ⓐ	Ⓢ	S	S	S/HA	S
6.2 Percussion	•	Ⓐ	Ⓢ	S	TH	S/HA	S
6.3 Suctioning							
6.3.1 Pharyngeal	•	Ⓐ	Ⓢ	S	S	S/HA	X
6.3.2 Tracheostomy	•	Ⓐ	Ⓢ	S	S	S/HA	X
6.4 Tracheostomy Tube Replacement	•	(EM)	(EM)	EM	EM	EM	EM
6.5 Tracheostomy Care (Cleaning)	•	Ⓐ	Ⓢ	X	X	X	X

DEFINITION OF SYMBOLS

A Qualified to perform task, not in conflict with professional standards
S Qualified to perform task with RN supervision and inservice education
EM In emergencies, if properly trained, and if designated professional is not available
X Should not perform

N Nutritionist only
TH Occupational or physical therapist only
SP Speech/language Pathologist only
○ Person who should be designated to perform task

HA Health Aide only

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1 Related Services include N, TH, and SP.
2 Paraprofessionals include teacher aides, health aides, uncertified teaching personnel.
3 Others include secretaries, bus drivers, cafeteria workers, custodians.

ELINEATION OF RESPONSIBILITIES MUST ADHERE TO EACH STATE NURSE PRACTICE ACT.

GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING *

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7.0 SCREENINGS							
7.1 Growth		Ⓐ	Ⓢ	S	S	S	X
7.2 Vital Signs		Ⓐ	Ⓢ	X	X	S/HA	X
7.3 Hearing		Ⓐ	Ⓢ	X	(SP)	S/HA	X
7.4 Vision		Ⓐ	Ⓢ	X	X	S/HA	X
7.5 Scoliosis		Ⓐ	Ⓢ	S	TH	S/HA	X
8.0 SPECIMEN COLLECTING/TESTING							
8.1 Blood Glucose	•	Ⓐ	Ⓢ	X	X	S/HA	X
8.2 Urine Glucose	•	Ⓐ	Ⓢ	X	X	S/HA	X
9.0 OTHER HEALTH CARE PROCEDURES							
9.1 Seizure Procedures		A	A	A	A	A	A
9.2 Soaks	•	Ⓐ	Ⓢ	X	TH	S/HA	X
9.3 Dressings, Sterile	•	Ⓐ	S	X	X	X	X

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PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL[1]	PARA PROFESSIONALS[2]	OTHERS[3]
10.0 DEVELOPMENT OF PROTOCOLS							
10.1 Health Care Procedures		Ⓐ	X	X	X	X	X
10.2 Emergency Protocols	•	Ⓐ	(WITH PHYSICIAN CONSULTATION)				
10.3 Individual Education Plan Health Objectives		Ⓐ	X	X	X	X	X
10.4 Nursing Care Plan		Ⓐ	X	X	X	X	X

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Source: Joint Task Force for the Management of Children with Special Health Needs. Guidelines for the Delineation of Rules and Responsibilites for the Safe Delivery of Specialized Health Care in the Educational Setting. Reston, Va: The Council for Exceptional Children, May 1, 1990.

National Association of

State School Nurse Consultants, Inc.

DELEGATION OF NURSING CARE IN A SCHOOL SETTING

New Demands on Nursing Services

Students with special health care needs are placing new demands for services on school districts across the nation. Local school boards are being asked to provide health care staff to perform a level of nursing service not seen before in the school setting. The reasons are four:

1. The trend toward outpatient and homebound treatment rather than treatment in an acute care setting;
2. Advances in medical technology which allow monitoring and health maintenance services outside the confines of acute care institutions;
3. The federal mandate for mainstreaming of special education students with complex health needs;
4. Parent's expectations regarding their child's right to care in the school setting.

These developments raise issues of educational placement, student safety, and school and professional liability that need to be addressed. In making decisions about educational placement of students with health care needs and who is to provide the nursing service, the primary concern must be for the health and safety of the student. The secondary concern is for the legal responsibility of all involved parties (e.g., the school board, school administrators, school staff and, in particular, the school nurse). School administrators are legally responsible for the safety of all students, and this responsibility includes the provision of required health services by qualified staff. Using non-qualified staff could risk potential harm to students. In addition, administrators must realize non-licensed school staff are liable if they practice nursing or medicine without a license.

Nurse's Responsibility for Quality Care

The nurse's ultimate responsibility is to the patient for the quality of nursing care rendered. If the nurse's decisions on care, and who can safely perform it, are in error, the student suffers. In addition, the nurse can be personally liable and possibly in violation of the nurse practice act, which might precipitate disciplinary action against his/her license to practice.

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School district administrators have the responsibility to determine educational placement of the student. Administrators are not responsible for deciding whether or not the required nursing service must be provided by a licensed health care provider. The registered nurse is required to make that decision based on the state nurse practice act.

If another licensed health care practitioner delegates nursing care to a non-licensed individual, while the nurse is responsible for the supervision, then the supervising nurse must make delegation determinations before assuming responsibility for the activity.

Questions About Delegating Care

There are two critical questions involved in delegating and supervising nursing care:

1. Is this a nursing task under the state's definition of nursing?

   Nursing and medical activities are defined by state statute and interpreted by state boards of nursing and state boards of medicine and/or state attorneys general and courts. Based on this definition, the nurse decides whether or not the procedure is one that must be performed by a registered nurse.

2. Can the procedure be rendered by non-licensed school staff under the supervision of a registered nurse?

   Nursing activities not specifically addressed in statute or legal interpretations can be performed by a non-licensed individual if the activity does not require the exercising of nursing judgment and if delegated and supervised by a registered nurse.

Determinations Required in Each Case

Given the above, the delegating and supervising registered nurse makes the following determinations for each student with health care needs and each nursing activity required on a case-by-case basis:

1. The nurse validates the necessary physician orders (including emergency orders), parent/guardian authorization, and any other legal documentation necessary for implementing the nursing care.
2. The nurse conducts an initial nursing assessment.
3. Consistent with the nursing practice act and related regulations of each state's board of nursing, and with his/her assessment of the student, the nurse determines who can be delegated the task--licensed (registered nurse or licensed practical vocational nurse), unlicensed health care provider or other staff person.
4. The nurse determines the amount of in-service training required for the individual performing the nursing service consistent with the Board of Nursing regulations governing the practice by unlicensed personnel.
5. The nurse evaluates the competence of the individual to safely perform the task prior to delegation.

6. The nurse provides a written care plan to be followed by the unlicensed staff person.

7. The nurse determines the amount and type of registered nurse supervision necessary.

8. The nurse determines the frequency and type of routine student health reassessment and reevaluation necessary for ongoing safety and efficacy.

9. The nurse provides in the care plan for instances when a change in student condition, performance of procedure or change in other circumstance warrants registered nurse intervention and/or reassessment.

10. The nurse determines and requires the amount and type of documentation to be done by unlicensed staff, consistent with the State's nurse practice act and rules promulgated by each State Board of Nursing.

11. The nurse documents activities appropriate to the nursing actions listed above.

If The School Is Not The Best Setting For Care

If the delegating and/or supervising nurse determines that a requested procedure may cause harm or cannot safely and efficaciously be performed in the school setting, the nurse should take the following steps:

1. Write a memo to his/her immediate supervisor explaining the situation in specific detail, including:
   a. The reason the procedure should not be performed in school, and a rationale to support this; or
   b. Recommendations for safe performance of the procedure in the school.
2. Maintain a copy of the memo for the school nurse's personal file.
3. Forward copy(ies) of the memo to one or all of the following as indicated: The State Board of Nursing, the district superintendent, and the state school nursing consultant.
4. Repeat notification that the requested procedure should not be performed in school until resolution of the issue.

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SCHOOL HEALTH ENVIRONMENT

GUIDELINES FOR SCHOOL HEALTH CLINIC

Legal Basis

None

Recommendation

Standard

According to the Southern Association of Colleges and Schools, the standards for a school health clinic environment include the following:

- Provision of health services to meet the immediate needs of students enrolled through the school rather than by an outside agency.
- Provision of appropriate health facilities, equipment, supplies, and personnel to fulfill the needs of students and staff.
- Development of a plan for handling injuries or illnesses of students and staff and making the faculty and staff familiar with the plan.

In accordance with these guidelines, recommendations for the school health clinic must be considered when new construction is being planned or when school buildings are being renovated. The supervisor/director/coordinator of school health services should be an active part of the advisory group designing any new health services area.

Space should be allocated in each school building to accommodate the activities of the health services program. The physical environment should convey a positive message about health while accommodating the needs of ill and injured students and staff. The space should be sufficient to permit the school health nurse to perform job responsibilities and maintain the privacy of persons seeking services.

The school health office should be planned to meet the needs of emergency care and outpatient clinic services. The design and equipment should include infection control considerations.

Location

- Centrally located on the school campus in a quiet area on the ground floor.
- Located near the administrative offices with easy accessibility for students and staff.
- Conveniently accessible for the disabled. Preferably designed with a door to the outside.

Physical Design

- A waiting area, clinic/work area, nurse's office area, bathroom facilities, and recovery rest rooms to accommodate the ill and injured (1 recovery couch per 400 students). A separate rest area for male and female students in secondary schools. Excluding bathroom and storage areas, the recommended workable space is 400 square feet.
- Adequate lighting and climate control.
- Enough space to accommodate screening (at least 22 feet in length).
- Entrances and doorways (including bathroom doorways) that will accommodate wheelchairs.
- A sink with hot and cold water equipped with a gooseneck faucet and a wrist control device, liquid soap, and paper towel dispenser, and separate from the bathroom sinks.
- Counter work area and closet storage space adequate to accommodate supplies and large equipment.
- Wall cabinet storage space, with lock, for medications and supplies.
- Quiet area that will accommodate audiometric screening and confidential health counseling.
- Adequate electrical outlets, approximately one every 6 feet.
- Nonabsorbent, easily cleanable flooring. Carpeting not acceptable.

Furnishings

- Waiting Room: Chairs, book case, small table, rack for informational pamphlets, and a bulletin board.
- Work Area: Refrigerator, balanced scale, examining lamp, desk and chairs, sink with hot and cold water equipped with a gooseneck faucet and wrist control device, secured file cabinets for records, emergency communication system, and a phone easily accessible to nursing functions.
- Bathroom Facilities: Toilet with wall rails, sink with hot and cold water, small cabinet for storage, and a shower (optional). Should be designed specifically for physically disabled persons.
- Nurse's Office Area: Desk and chair seating for students/clients, secure file cabinet for health records, book case, and a desk phone.
- Recovery Rest Areas: Recovery couches with washable surface (1 per 400 students), chairs and folding panel screens or privacy curtains, and bedside tables (1 per couch).

Recommendations for furniture and equipment in the school health office are listed in Table 1.

Recommendations for expendable (consumable) supplies that would be necessary in the school health office are listed in Table 2.

Table 1 School Health Office: Recommendations for Furniture and Equipment

- Apothecary jars
- Audiometer
- Beds (preferably covered with vinyl or other easily cleaned material)
- Bedside tables, one per bed
- Book cases
- Bookends
- Bulletin boards
- Chairs
- Clipboard
- Communicable disease chart
- Crutches
- Desk and desk chair
- Desk calendar
- Emergency care flip chart
- Emesis basin
- Examining lamp
- Eye irrigating bottle
- File for emergency cards
- Hardback notebooks (loose-leaf)
- Health records
- Heating pad
- Hot water bottle
- Ice chest
- In/out baskets
- Locking box for medications in the refrigerator
- Locking cupboard for medication
- Metal file cabinet with lock for health records
- Mirror
- Pamphlet rack
- Paper clip dispenser
- Paper towel dispenser/paper towels
- Reflex hammer
- Refrigerator
- Regular wastebasket
- Regular 8" scissors
- Resource books
- Resuscitation masks (pediatric and adult)
- Scales, balanced, upright, on wheels
- Screens, or curtains for privacy
- Small table
- Stapler
- Stationary measuring device or flat metal tape and right angle headboard
- Stretcher
- Tape dispenser
- Tape measure
- Telephone
- Vision screening equipment and manuals; i.e., Snellen Chart, Titmus Screener
- Wall clock with second hand
- Wall storage unit for extra supplies
- Wash basins
- Wastebasket with foot pedal
- Wheelchair

If physical exams are performed in schools, the following equipment would be needed:

Hemoglobin screening device

Recommended resource books include:

American Public Health Association. Control of Communicable Disease in Man. Washington D.C.: the Association, 1990.

Lewis, Keeto D., and Thomson, Helen B. Manual of School Health. Addison-Wesley Publishing Company, Inc., 1986.

Berkow, Robert, M.D., ed. The Merck Manual of Diagnosis and Therapy. Rahway, NJ: Merck and Company, Inc., 15th edition, 1987.

Medical dictionary

Current pharmacological reference

Current resource on birth defects

Table 2 Recommendations for Expendable (Consumable) Supplies

Adhesive bandages, ½" (juniors)
Adhesive bandages, 3/4" (strips)
Adhesive bandages, 1" (strips)
Adhesive bandages, butterflies
Adhesive skin closures
Alcohol
Bandage scissors
Batteries for ophthalmoscope/otoscope
Blankets
Bleach
Calamine lotion
Cotton balls
Cups, paper, 3-4 oz., waxed
Cups, plastic medicine
Dental floss
Disinfectant for thermometers
Disposable latex gloves
Elastic bandages, 2", 3", 4"
Emergency drugs per locality's protocol
Eye pads
Fingernail clippers
Finger splints
Flashlights/penlights
Forceps, straight
Hazardous waste container for needles/syringes
Ice bags, reusable, various sizes
Maxi- and mini-pads
Non-stick, sterile gauze pads, 3"x4"
Non-stick dressings
Ointment, petroleum
Ophthalmoscope/otoscope
Pens, pencils, ruler, paper clips, thumb tacks, needles, thread, buttons, and other miscellaneous office supplies
Physician roll paper
Pillows
Pillow covers, plastic
Plastic bags, small, resealable
Plastic liners for wastebasket
Safety pins
Salt
Soap dispenser
Soap, liquid antimicrobial
Splint boards (large-18"x3")
Sphygmomanometer, obese adult, average adult, child sizes
Spray disinfectant
Sterile gauze pads, 2"x2" and 4"x4"
Stethoscope
Stretch gauze bandage, 1", 2", and 3" rolled
Syrup of Ipecac
Tampons, super and regular
Tape, adhesive, 1" and 2"
Tape, hypo-allergenic
Temp-strips for special need students
Thermometer sheaths as appropriate
Thermometers, oral, bulb-tip, glass, or electronic/digital
Tissues
Tongue depressors
Triangular bandages (slings)
Tweezers

If physical exams are performed in schools, the following supplies would be needed:

Uristix/Chemstix for urine screening
Supplies for hemoglobin screening device
Paper measuring tapes
Urine collection cups

GUIDELINES FOR A HEALTHFUL SCHOOL ENVIRONMENT

INTRODUCTION

Legal Basis

There a numerous laws, regulations, codes, and policies that set requirements for the operation of a healthful school environment. Consult identified areas in this section for specifics.

Recommendation

Introduction

Since children are required to spend many hours of their lives in school, a safe and healthful environment must be provided for them. This should include both the physical and emotional environment. The health of the school personnel also has an influence on the students and the environment.

The purpose of this section, Guidelines for a Healthful School Environment, is to provide recommendations concerning safety, occupancy, use, sanitation, maintenance, and operation to safeguard the health of the school occupants and the general public.

Each section contains recommendations that have been adapted from the publication Colorado School Health Guidelines, Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

Emotional Environment

The emotional environment of schools has become a more recent concern to administrators, teachers, nurses, and parents. Teacher-student and student-student relationships should foster good mental and emotional health attitudes and behavior. The teacher's health status, teaching techniques, and emotional attitudes set the climate in the classroom. These contribute to sound learning. Perhaps one of the most important contributions a teacher or nurse can make is to be alert: alert to each child's personality, assets and liabilities, and problems and needs. Also, the teacher and nurse should always bear in mind that the "average" child seldom exists, that each child is a fascinating array of variations.

Physical Environment

Role of the School Nurse/Principal's Designee:

The role of the school nurse/principal's designee is to observe and report conditions in the school environment that create health and/or safety hazards. This report should be made to the school principal or his/her designee who is responsible for seeing that such conditions are corrected.

Responsibility of Local School Division:

Local school divisions are responsible for being aware of and for complying with any local, state, and federal ordinances, codes, rules, and regulations that apply to the health and safety of the environment.

Inspection:

It is recommended that all schools should be inspected at least once per year. If a school is provided with a non-community water system, the water supply system should be inspected a minimum of once every six months and water samples taken for testing. School food services inspections should be conducted in accordance with the Virginia Rules and Regulations Governing Restaurants.

New Construction/Building Maintenance:

All public school division facilities that are constructed or remodeled must meet the most current edition of the Virginia Uniform Statewide Building Code (Virginia USBC) that is based on the Building Officials and Code Administrators (BOCA) National Codes.

"The Code of Virginia directs the Board of Housing and Community Development to adopt and promulgate a Uniform Statewide Building Code (USBC) to provide mandatory, statewide, uniform regulations for the construction, maintenance, and use of buildings and structures. To satisfy this mandate the Board has developed two volumes of the USBC; Volume I regulates new construction, and Volume II regulates the maintenance of existing buildings and structures. Volume I must be complied with when a building or structure is constructed, altered, enlarged, repaired or converted to another use. Volume II requires that all existing buildings and structures be properly maintained to protect the occupants from the health and safety hazards that might arise from improper maintenance or use of the building."

References:

Virginia Uniform Statewide Building Code: Volume I New Construction Code. Commonwealth of Virginia, Board of Housing and Community Development, 1990 Edition - First Amendment Effective November 1, 1991.

Virginia Uniform Statewide Building Code: Volume II Building Maintenance Code. Commonwealth of Virginia, Board of Housing and Community Development, 1990 Edition Effective March 1, 1991.

GROUNDS

Recommendation

General

- The grounds should be self-draining and free from depressions in which water might stagnate and serve as a breeding ground for mosquitos or cause other hazards.

- Entrance walks, building entrances, and similar areas should be illuminated at night when they are in use.

- The grounds, building, hallways, and at least one building entrance should be designed to facilitate the entry, egress, use, and mobility by physically disabled persons.

- Livestock or poultry should be located more than 50 feet from food service areas, offices, or classrooms except those offices and classrooms associated with animal husbandry programs.

- Service roads, parking areas, and walkways should be maintained to facilitate the movement of vehicular and pedestrian traffic to avoid personal injury.

- Adjacent highways or roadways should be posted to reflect school zones, alerting the public to reduce speed.

- A designated area should be provided for bicycle parking. The location of the bicycle parking area should not obstruct pedestrian or vehicular traffic, building exits, or fire lanes.

- Walks, ramps, and steps should be maintained to protect users from personal injury. The walkways should be free from obstructions and hazardous accumulations of snow and ice. Mud/sand grates and mud scrapers should be maintained to avoid injuries.

Playgrounds

- Playground equipment should be constructed of durable weather-resistant materials. The equipment should be sturdy and suitable for the intended use.

- Playground equipment should not create a hazard for students and should be maintained and kept in good repair. Equipment should be free of projecting screws and bolts, sharp cutting edges, pinch points, and splinters.

- A protective surface such as pea gravel, sand, mulching, or other approved shock absorbing material should be provided on the ground where play equipment is located.
- The playground area should be free of tripping hazards. All obstacles and equipment less than 4 feet in height should be finished in a contrasting color(s) so as to be clearly seen.
- The diameter of the ring openings and clearances between structural members should not be less than 5 1/2 inches or greater than 9 inches.
- All playground equipment should be designed to minimize the danger of injuries. Ladders intended for foot use should have a minimum incline of 15° forward from vertical and adequate grab rails on both sides.
- Large irrigation pipes, manholes, ponds, or similar hazards should be covered and locked or fenced to prevent unauthorized access.
- Shaded areas should be available at all times to protect children from the sun and heat.

Water Supply

- The water supply system should provide a safe, potable, adequate water supply that meets the requirements of the state health department, including the Virginia State Waterworks Regulations, Drinking Water Regulations, and where applicable, Virginia Department of Health Private Well Regulations.
- The water supply system should deliver water at normal operating pressures (20 pounds per square inch minimum) to all plumbing fixtures.
- When a total water service interruption exceeds a period of 2 hours, the school should be closed, unless dismissal of the pupils would be detrimental to their physical well-being, or unless accessible approved alternatives for providing potable water are available that meet the requirements of the state health department.
- Faucets on non-potable water supply systems used for irrigation or similar purposes should be physically separated from the potable water and meet the requirements of the state health department.
- The water storage, distribution system, treatment facilities, and other mechanical

equipment should be protected from unauthorized access.

- Where water is supplied by the school's independent water supply system, plans for the water system should be submitted to the state health department for approval prior to construction.

- The water supply system should meet the requirements of the Lead Contamination Control Act (LCCA) of 1988 with respect to lead materials in the system.

Sewage Disposal

- Facilities, approved by the state health department, should be provided and maintained for the treatment and sanitary disposal of sewage.

- Where a public sewer system is available, all plumbing fixtures and all building sewer lines should be connected thereto.

- If a public sewer system is not available, a sewage disposal system meeting the requirements of the state health department should be provided, and all plumbing fixtures, and building sewer lines should be connected thereto.

- Where a total interruption of sewer service exceeds a period of 2 hours, the school should be closed unless dismissal of the pupils would be detrimental to their physical well being, or unless accessible approved alternatives for the sanitary disposal of sewage are available.

- Where nonwater carriage sanitary facilities are permitted, they should be provided and installed in accordance with requirements of the Sewage Handling and Disposal Regulation.

- In all new schools and schools modifying existing sewage disposal systems or expanding their usage beyond the design capacity of the sewage disposal system, plans should be submitted to the state health department for review and approval in accordance with provisions of the most current edition of the Virginia Uniform Statewide Building Code.

Refuse Disposal

- The storage, collection, transportation, and disposal of refuse should be conducted to control odors, insects, rodents, communicable disease, accidents, or other nuisance conditions.

- Durable nonabsorbent, cleanable refuse containers should be provided, kept in a clean condition, and placed in readily accessible locations.

- Universal precautions, including the wearing of gloves should be used in cleaning up blood and body fluids. All blood and body fluids should be decontaminated prior to wiping up with 1:10 solution of sodium hypochlorite (household bleach) or other Centers for Disease Control (CDC) approved solutions. For further information, please see Section III. Services: Universal Precautions.

- All bio-hazard wastes such as refuse from the health clinics or from cleaning of blood and body fluids should be double bagged with plastic waste bags and sealed prior to placing in refuse containers for disposal.

- All sharp-edged instruments, such as blades from exacto knives, blades from saws, or needles from hypodermic syringes, should be placed in hardwall containers and labeled and sealed prior to disposal. Local schools should contact the local health department or local medical facility for assistance with disposal of the hardwalled containers.

- Exterior refuse storage areas should be kept in a clean, sanitary condition. Refuse receptacles for exterior storage of garbage or putrescible wastes should be provided with covers. Exterior refuse containers should be stored on a smooth surface on nonabsorbent material such as asphalt.

- Exterior putrescible waste storage areas should be located a minimum of 25 feet from food services areas and classrooms.

- Refuse should be removed from the buildings and removed from the premises as often as necessary, but not less than twice weekly when putrescible wastes are stored.

Insect and Rodent Control and Classroom Animals

- Rodents and insects should be controlled to maintain the facility free from vermin.

- Animals used for instructional purposes should be maintained in a sanitary condition and in a manner to prevent health hazards or nuisance conditions and to conform to local school policy.

- All pesticides should be used in accordance with registered label directions and stored in a safe manner in an area accessible only to authorized personnel. Application of "restricted use pesticides" should be performed only by a certified pesticide applicator.

Plumbing

- In the absence of more stringent plumbing codes, the most recent edition of the Virginia Uniform Statewide Building Code should be used as a guideline for the installation and maintenance of all plumbing fixtures.

- Plumbing fixtures should be maintained in working order and in a clean sanitary condition. All plumbing fixtures should be designed and maintained to be accessible by the age group being served.

- The potable water supply should be installed and maintained to preclude the possibility of polluted water flowing into the potable water system.

- A properly installed, approved backflow prevention device should be provided for all potable water supply outlets which are capable of receiving a hose connection.

Toilet, Lavatory, Bathing Facilities, and Drinking Fountains

- Toilet, lavatory, bathing facilities, and drinking fountains should be provided and should be accessible for use by individuals with disabilities.

- Drinking fountains should be conveniently located on each floor and should be easily accessible to all school program activities. Drinking fountains should not be installed on sinks in bathrooms used for handwashing or arts and crafts or on sinks in toilet, science, or art areas. Drinking fountain spouts should be of angle jet construction.

- Use of common drinking cups or vessels should be prohibited.

- Toilet rooms should be conveniently located at a travel distance of not more than 200 feet from any room to be served. All toilet rooms should be provided with adequate lavatory facilities.

- Soap and single service towels should be available for all lavatory facilities; however, mechanical warm air dryers may be used in lieu of towels.

- Hot and cold water or tempered water under operating pressures (20 PSI minimum) should be available for bathing and washing. Hot water delivered to showers and lavatories should not exceed 110° F. The temperature of hot water at other fixtures should not exceed 120° F, except where necessary for sanitizing purposes.

- Toilet bowls should be equipped with nonabsorbent, sanitary toilet seats. Toilet paper should be available at each toilet mounted in an appropriate dispenser.

- Floors, walls, and ceilings of all toilet, shower, and locker rooms should be smooth, easily cleanable, non-absorbent and should be maintained in good repair and in a clean, sanitary condition.

- In new construction, a floor drain and a keyed hose bit with a vacuum breaker should be available for all toilet rooms having a total combination of two or more water closets or urinals. The floors in these rooms should slope to the floor drains.

- A minimum of 9 square feet of floor should be provided per shower head in existing structures. New structures should have 12 square feet of floor area per shower head. Centralized shower heads should be located at least 3 feet apart. Floor drains in centralized showers should be located to prevent water from one shower head draining across occupant area of another shower head. Showers should be constructed to prevent water flow into the drying or dressing room space. Shower floors should have a nonskid surface.

- Functional water outlets should be available, where necessary, at designated refuse storage areas and at high-density student common use areas within 50 feet of the building where heavy accumulations of refuse are generated to minimize hazards and to maintain such areas in a clean, safe condition.

- Plans and specifications for the installation of sanitary facilities in schools that are being remodeled to increase the occupant load should be submitted for review and approval in accordance with state health department regulations prior to construction.

- Swimming pools should be constructed, operated, and maintained in accordance with local regulations.

Building, Occupancy, Space, and Use

- The school plant and accessory buildings should be maintained in good repair and in a clean sanitary condition. In the absence of more stringent applicable construction codes or related standards, the most current edition of the Virginia Uniform Statewide Building Code should be used as a guideline for the construction, maintenance or alteration of school buildings.

- Any projections from the ceiling should be a minimum of 6 feet, 8 inches vertical distance from the finished floor. If adherence to this height requirement is not possible, approved protective measures should be taken to minimize hazards and caution signs should be installed where necessary.

- Hallways, ramps, and steps should be maintained to protect users from personal injury. Walkways and stairways should be free from obstructions.
- All designed emergency exits should be clearly marked. Exit doors should be equipped with panic bars. Fire extinguishers should be placed in the school in appropriate places. Emergency exit corridors should be provided with approved emergency lighting. In the absence of more stringent codes, the most recent edition of the Virginia Uniform Statewide Building Code should be used as a guideline for determining emergency lighting and emergency exit requirements.
- Adequate space should be provided for each person in classrooms, libraries, shops, laboratories, vocational training rooms, dining rooms, and other related activity rooms or areas to reduce the possibility of health hazards and transmission of diseases. In the absence of more stringent guidelines, the most current edition of the Virginia Uniform Statewide Building Code should be used as a guideline for determining adequacy of space.
- Where necessary, classroom windows should be equipped with blinds, shades of translucent material, or other effective means to prevent glare and to control natural light.
- Windows, when opened, should not create a hazard and should be screened to keep out insects.
- Exposure to noise, dusts, toxic chemicals, or other hazards should be controlled when the building or any portion thereof is occupied during construction or remodeling.
- When there is a change in classroom use, the design and construction of classroom facilities should be appropriate to accommodate the change.
- All visitors should be required to register at the office when they enter or leave a school building. This requirement should be posted in highly visible areas in the school building.

Reference

Adapted from: Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

MECHANICAL OPERATIONS

Recommendation

Electrical

- Schools should be provided with operational electrical service and artificial lighting throughout the building.

- The electrical system should be maintained in good repair and should not present a hazard to health and safety. In the absence of more stringent electrical codes, the most recent edition of the National Electrical Code should be used as a guideline for the installation, maintenance, and use of the electrical system.

Lighting

- The electrical lighting system should be capable of providing the following average light level intensities: 70 foot candles for classrooms, libraries, offices, laboratories, and shops; 100 foot candles for drafting, typing, sewing rooms, and other rooms where close eye task activities are routinely conducted; 30 foot candles for reception rooms, rest rooms, gymnasiums, service rooms, swimming areas, and dining areas, 15 foot candles for auditoriums, locker rooms, and stairways; and 20 foot candles for corridors, hallways, storage, and utility areas. Light level intensities should be measured at the work surface or 30 inches from the floor.

- Extreme brightness ratios (glare and shadow) should be minimized by avoiding glossy surfaces; by use of diffused lighting; by use of easily cleanable high light reflectance paints or other finishes for ceilings, walls, and floors; by use of window shades, routine cleaning and maintenance of electrical fixtures; and/or by other measures necessary to prevent undue glare and maintain a high level of light effectiveness.

- Appropriate measures should be taken to assure that persons are not exposed to lighting which may be harmful to the eyes, such as ultra-violet light.

- Glare control from direct sunlight is recommended in spaces where reading is an assigned task.

Ventilation

- Mechanical or natural ventilation should be maintained to minimize health hazards including excessive drafts, extreme temperature and humidity, and fluctuations in temperature. The American Society of Heating, Refrigeration and Air Conditioning Engineers most recent edition of Standard 62 Ventilation for Acceptable Indoor Air Quality should be used as a guideline for proper indoor ventilation.

- Public schools must conform to local and state laws regarding smoking. As of July 1, 1990, the Code of Virginia Section 15.1-291.2. Statewide regulation of smoking prohibits smoking in "...public school buses;...common areas in any public elementary, intermediate, and secondary school, including, but not limited to classrooms, hallways, libraries, auditoriums, and other facilities;..."

- Ventilation system filters should be cleaned on a quarterly or 6 months schedule or replaced as needed to prevent excessive accumulation of dust or debris.

- Each room provided with an exhaust system should have fresh air supplied to the room equal to the amount discharged. Windows should not be used for the purpose of providing makeup air.

- Unvented combustion heaters, kitchen stoves, or hot plates should be prohibited for space heating purposes. Portable electric heaters with exposed elements should not be used in any student activity area.

- Hot plates, skillets, or similar cooking appliances should be used for food preparation only in the kitchen, home economics room, or in rooms specifically designated and equipped for such use.

Heating

- The heating system should be properly maintained and should be capable of providing a minimum room temperature of 60° F, 60 inches above the floor in gymnasiums; 65° F, 30 inches above the floor in shops; 68° F, 30 inches above the floor in elementary, secondary, and higher education classrooms; and 68° F at the floor level in kindergartens (except that lower minimum room temperatures may be deemed acceptable during temporary extreme conditions).

Equipment and Supplies

- Instructional, athletic, recreational, or other equipment used in or out of the classroom should be maintained in a clean, safe condition.

- Toys and equipment should meet applicable state and local regulations.

- Gym equipment should be kept clean and in good repair. Body contact equipment surfaces should be routinely cleaned with an approved sanitizer.

- Equipment used in physical therapy and special education should be cleaned after it is used.

- Facilities should be available for the proper storage of clean clothing and of athletic, instructional, and recreational equipment and supplies to minimize health hazards and to facilitate cleaning.

- Cleaning materials, tools, and maintenance equipment should be provided and should be stored safely and secured in a locked area.

- Pesticides and toxic or hazardous cleaning and maintenance chemicals and materials should be stored separately in a ventilated and locked cabinet or in an area accessible only to authorized personnel. The ventilation recommendation of this section may not be recommended in areas where minimum quantities of the above mentioned materials are stored for daily use. Flammable or combustible materials should be stored in accordance with the most recent edition of the National Fire Protection Association 30 Flammable and Combustible Liquids Code.

- Kindergartens, health service rooms, or other areas where sleeping is permitted, should be provided with sleeping facilities including cots or pads with washable or disposable covers. Sleeping facilities should be maintained in good repair and in a clean condition for each user.

- Towels and wash cloths, and other linens, where provided should be laundered to insure exposure to water temperature of at least 130° F for a combined wash and rinse period of at least 25 minutes or an equally effective washing procedure. 200 ppm chlorine should be applied in the final rinse cycle - and test papers should be provided to assure this. Linens, towels, and wash cloths should be issued clean, used by only one person, and laundered after each use.

Reference

Adapted from: Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

SCHOOL FOOD SERVICE

Recommendation

Preparation

- Each school preparing food either off site or on site, or serving food should obtain a health department permit as required by provisions of the Virginia Rules and Regulations Governing Restaurants.

- Food service activities should be conducted in conformance with the physical and operational requirements of the Virginia Rules and Regulations Governing Restaurants.

- Food served by the school but not prepared on site should be obtained from sources that are inspected and approved by the state health department. The food should be transported, stored and served in a manner that assures the maintenance of proper temperatures and prevents contamination or adulteration.

Dining Facilities

- Dining activities should be confined to rooms or areas designated by the school administrator. The dining area should be maintained clean, and in a sanitary condition.

- Plans and specifications for construction or alteration of food service facilities should be submitted in accordance with the requirements of the Virginia Rules and Regulations Governing Restaurants.

Reference

Adapted from: Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

LABORATORY, INDUSTRIAL, ART, AND VOCATIONAL HAZARDS

Recommendation

General

- Provisions should be made for the protection of students engaging in arts, crafts, industrial arts, physical sciences, vocational education or in any activities where hazardous chemicals, hazardous devices, or hazardous equipment are used. These provisions include the development and posting of operating instructions, regulations, and procedures.

- Toxic or hazardous materials should be stored in approved laboratory containers, separated by reactive group, and stored in a ventilated, locked, fire-resistant area or cabinet. The ventilation recommendation of this section may not be recommended where minimum quantities of such materials are stored for daily use.

- Containers of chemicals, poisons, corrosive substances, and flammable liquids should be clearly labeled with the name of the material and the date the material entered the school.

- Exposure to noise, or toxic liquids, dusts, gases, mists, vapors, or other hazards should be controlled to avoid health hazards.

- All chemicals, solvents, and hazardous substances should be inventoried by the school a minimum of once a year. The inventory should include the name of the compound, the amount, and the date it entered the school.

- A current material safety data sheet should be provided for all poisonous, toxic, or hazardous substances and should be available for review upon request.

- The appropriate National Fire Protection Association Codes should be used as guidelines for the proper storage, handling, and use of chemicals in the school.

- Where refrigerators are used to store flammable compounds, they must be explosion proof.

- A written plan for response to and cleanup of chemical spills should be provided by the school.

- A written plan that explains the proper storage, handling, and disposal procedures for all poisonous, toxic, or hazardous substances should be on file in each school and should be available for review upon request.

- A list of first aid procedures for accidental poisoning should be posted. The telephone number and location of the nearest poison control center should be posted near the telephone and written on the front cover of the flipbook First Aid Guide for School Emergencies (the flipbook should be kept in the school nurses's office or school health room). All incidents should be reported according to local policy.

- The storage, preparation, and consumption of food and drink is prohibited in any area where there are poisonous, toxic, or hazardous substances.

- Glassware should be properly constructed and designed for its intended use and should be handled and stored in a safe manner.

- Aspirators or suction bulbs should be used for drawing liquids into pipets. The mouth should not be used directly on the pipets.

- Eye protection devices that are in compliance with of the Code of Virginia Section 22.1-275. Protective eye devices must be worn by all students participating in, observing, or in close proximity to any experiment or activity that could result in eye injury. Eye protection glasses, goggles, face shields, and similar eye protection devices should be issued clean and properly sanitized and stored in a protected place. Please see Section VI. Code of Virginia: Safety and Clean Air for code excerpt.

- An easily accessible fire blanket should be provided in each laboratory or other areas where an open flame is used.

- Where there is exposure to skin contamination with poisonous, infectious or irritating materials, a hand washing facility should be available.

- An easily accessible operational eye wash fountain should be provided in each laboratory or other areas where corrosives or irritating chemicals are used. The eye wash fountain should be clean and must be tested annually. The use of portable eye wash bottles as substitutes should not be permitted.

- An easily accessible operational safety shower, capable of providing continuous flowing water, should be provided for each laboratory or other areas where corrosive or irritating chemicals are used. The safety shower can be centrally located to serve more than one area if doors are not locked and prompt access is available.

- Master gas valves and electric shut-off switches should be provided in each laboratory or areas where power equipment is used. Electric shut-off switches are not permitted to be located in fuse boxes.

- All emergency and safety equipment, including master valves, shut-off switches, eye wash fountains, safety showers, fire extinguishers (appropriate for the intended use), and fire-alarm pull stations and other similar equipment, should be tested once annually and labeled for high visibility.

- Use of X-ray machines and other electronic devices producing ionizing or non-ionizing radiation and radioactive materials and equipment should conform to the most recent edition of the Virginia Rules and Regulations Pertaining to Radiation Control, as amended.

Ventilation

- All areas should be adequately ventilated so that exposures to hazardous or toxic materials are maintained at a safe level. In absence of more stringent guidelines, the most recent edition of the American Conference of Governmental Industrial Hygienists' publication Threshold Limit Values and Biological Exposures Indices should be used as a guide to determine safe levels.

- Local exhaust ventilation should be provided so that contaminants are carried away from the student and not through the breathing zone.

- Sufficient fume hood capacity ventilation should be used for any activity producing hazardous toxic or noxious gases, mists, vapors, or dusts.
    - Hoods should exhaust directly to the outside and should be located a minimum of 10 feet from any building air-intakes or building openings.
    - Discharges from any exhaust hood should meet applicable Virginia Air Pollution Standards.
    - A minimum force velocity of 100 feet/minute for general laboratory hoods should be provided.
    - Air flow of fume hoods should be tested at least once a school year.

Reference

Adapted from: Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

EMERGENCY HEALTH SERVICE

Recommendation

First Aid/Emergency Care

- Basic first aid equipment and medical supplies as recommended by the most recent edition of the flipbook First Aid Guide For School Emergencies should be provided and kept conveniently available for emergency use.

- According to the Standards for Accrediting Public Schools in Virginia, Commonwealth of Virginia, Department of Education, July 1988: "Each school shall have at least two full-time staff members who have attended and successfully completed courses approved by the State Board of Health in all of the following: cardiopulmonary resuscitation(CPR), Heimlich maneuver, and basic first aid."

  A list of persons currently certified, as described above, should be maintained in each school office.

- Separate rooms or areas should be available in every school for emergency use in providing care for persons who are ill, infested with parasites, or suspected of having communicable diseases.

- Every emergency care room or area should be provided with at least 1 cot for each 400 students or part thereof. Each cot should have an easily cleanable, non-absorbent surface or cover which is sanitized after each use.

- Telephone or radio communications should be available in each school for emergency purposes.

- All accidents and/or incidents should be reported and documented according to local school division policy.

- The flipbook First Aid Guide for School Emergencies and a current list of emergency services with telephone numbers should be posted in one or more prominent place(s) in each school.

- A written plan for handling internal and external natural or man-made disasters should be prepared by each school. A copy of this plan should be maintained in each school. Disaster training and review should be conducted each year at each school. Principals, school personnel, and students should periodically review and test each disaster plan. Please see Section III. Services: Special Health Services - Management of Disasters.

Medication

- Medication should be present in a school only on a current individual prescription basis and should be administered only as prescribed by written authorization of a physician and parent. These orders should be renewed according to local policy. Such medications should be kept in the pharmacy labeled bottle. An individual record should be kept of medications administered by school personnel.
- Medications administered at the school should be stored in a secure double locked, clean container or cabinet.

School Health Clinic

Please see Section II. of this document, Environment: Guidelines for School Health Clinic.

Reference

Adapted from: Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986

MISCELLANEOUS

Recommendation

Asbestos Management

- An asbestos management plan complying with the provisions of the Virginia Air Quality Control Commission Regulation should be on file in each school, available for review by the state health department.

Radon Tests

- Each school should have completed radon tests by March 1, 1991. Radon tests should be conducted pursuant to the procedures described in the Environmental Protection Agency's Radon Measurements in Schools, an Interim Report, March 1989. The results of these tests should be on file at each school and available for review.

- Procedures should be established in each school division to provide for the protection of the health of the students and staff.

Fire Control

- The school plant should be maintained and used in a safe manner to minimize health, safety, and fire hazards. Fire control methods should conform to state and local fire prevention regulations.

School Buses

- School buses should be operated and maintained to avoid health and safety hazards and in accordance with state and local laws and policies governing pupil transportation.

Reference

Adapted from: Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

STUDENT HEALTH SERVICES

HEALTH AND PHYSICAL ASSESSMENT

SCHOOL ENTRANCE PHYSICAL ASSESSMENT

Legal Basis

Code of Virginia Section 22.1-270. Preschool physical examination.

Excerpt:

See Section VI. of this document, Code of Virginia: Attendance Requirements.

Note:

Preschool

The term "preschool" in relationship to the preschool physical examination means prior to school entrance.

The Code of Virginia requires all students entering kindergarten or elementary school for the first time to have the physical examination report placed in the child's school health record. All students transferring to Virginia elementary schools must meet this requirement.

Elementary School

Section 22.1-270 of the Code of Virginia does not define "elementary school" for the purpose of the school entrance physical examination. However, the publication Standards for Accrediting Public Schools in Virginia, Commonwealth of Virginia, Department of Education, July 1988, defines elementary school as kindergarten through grade 5.

Best practice indicates that "elementary" should be defined as through grade 8 for the purpose of the school entrance physical examination. Ideally, every student through the 12th grade should have a physical examination prior to school entry.

Recommendation

Purpose

The purpose of the health appraisal prior to school entrance is to identify physical, mental, and emotional health problems that may affect a student's achievement in school. Early detection of children with problems or developmental delays makes possible treatment and/or educational assistance to prevent aggravation of academic and behavioral difficulties.

Procedure

The primary responsibility for children's health care rests with the family. Every student should have a regular and continuing source of health supervision: a private physician, a health maintenance organization, or a publicly funded medical facility; the health appraisal should be performed by one of these providers.

Scope/Follow-up

Comprehensive Physical Examination Report (Code of Virginia Section 22.1-270, A-H):

The scope of the comprehensive physical examination is prescribed by the State Health Commissioner (Section 22.1-270 of the Code of Virginia). It includes health history, physical examination, and certification of immunization information. The extent of the information needed is contained on the most recent edition of the Commonwealth of Virginia School Entrance Physical Examination and Immunization Certification form. Pre-school physical examinations conducted on or after October 1, 1992 must be documented on Form MCH-213C (MCH-213C replaces MCH-213B)

Please see Section VIII. of this document, Virginia Forms, for a copy of the most recent form, MCH-213C.

The health history is as important as the examination itself and should not be limited to filling out of a questionnaire by the parent. If the school nurse takes the complete health history, its salient facts should be reviewed by the examiner.

In some cases, the physical examination may be performed at school. When this is done, each child should be examined individually in a private setting. Line-up examinations are insensitive to the individual's right to confidentiality. Parents should be present, if possible.

Results of the health appraisal and other health information relevant to the student's education or physical exercise program with recommendations for follow-up are recorded on the School Entrance Physical Examination and Immunization Certification form (MCH-213C). The school nurse is responsible for referral and follow-up of problems discovered at school.

Health Information Form (Code of Virginia Section 22.1-270, I):

The School Entrance Health Information Form provides health information on entering students.

Please see Section VIII. of this document, Virginia Forms, for a copy of the most recent School Entrance Health Information Form (Form HPE-h12 12/83).

ATHLETIC PHYSICAL ASSESSMENT

Legal Basis

School Policy

Pre-participation physical examinations of high school athletes are required after June 1st of each year by the Virginia High School League (VHSL) to be eligible to compete in a varsity sport.

Recommendation

Rationale

The athletic assessment includes all components of the Virginia School Entrance Physical Examination and Immunization Certification form as well as certain orthopedic evaluations of the musculo-skeletal system to identify a student at high risk for injury during participation in sports. The VHSL has designed its own comprehensive form.

Please see Section VIII. of this document, Virginia Forms, for a copy of the most recent athletic physical assessment form.

Procedure

The athletic physical assessment is best performed by the student's ongoing health care provider. In practice, however, most athletic examinations are done in large groups in the school gymnasium. Certain aspects of the examination can be done in line-up fashion. However, a separate room should be provided for the private aspects of the examination rather than omitting them.

The completed forms should be reviewed by the school nurse or other health professional to clarify questionable health information.

This form should become part of the student's permanent health record and should be filed at the end of the season.

SPECIAL EDUCATION MEDICAL ASSESSMENT

Legal Basis

Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia, Effective July 1, 1990; Amended August 1, 1991.

Excerpt:

In Part III: Responsibilities of Local School Divisions and State Agencies, Section 3.3 (G), the regulations state:

"Assessment Components

The eligibility of children for special education programs and related services shall be based upon a formal assessment involving the components as follows:

1. Educational:...
2. "Medical: written report from a licensed physician indicating general medical history and any medical/health problems which may impede learning."
3. Sociocultural:...
4. Psychological:...
5. Developmental:...
6. Other, such as speech, language, clinical/psychiatric, etc., where appropriate and/or necessary..."

Note:

Please see end of this section, "Additional Information," for complete Section 3.3(G) text.

Definitions

The following definitions are from Part I, Definitions, of the regulations.

Medical Services:

" 'Medical services' means services provided by a licensed physician to determine a child's medically related handicapping condition which results in the child's need for special education and related services."

Handicapped Children:

" 'Handicapped children' means those children evaluated, in accordance with these regulations, as being mentally retarded, hard of hearing, deaf, speech or language impaired, autistic, visually impaired, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf-blind, severely and profoundly handicapped, multihandicapped, or having a specific learning disability, who, because of these impairments, need special education and related services."

[Note: Public Law 101-467, the Individuals with Disabilities Act of 1990, replaced the term "handicapped" by the term "disability." For further information, please see Section V. Students with Special Needs: Public Law 101-476.]

Orthopedically Impaired:

" 'Orthopedically Impaired' means a severe orthopedic impairment which adversely affects a child's educational performance. The term includes impairments caused by congenital anomaly (e.g., club foot, absence of some member, etc.), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis, etc.), and impairments from other causes, (e.g., cerebral palsy, amputations, and fractures or burns which cause contracture)."

Other Health Impaired:

" 'Other Health Impaired' means having limited strength, vitality or alertness due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, arthritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes which adversely affect a child's educational performance."

Current Evaluation:

" 'Current Evaluation' means one that has been completed within 365 calendar days or less."

Recommendation

Medical History

Obtaining a complete medical history is the most important aspect of a health examination. For younger children, the parents are the primary informants. If the school nurse completes the health history, the salient facts should be reviewed by the examiner prior to medical assessment.

Items to include are as follows:

- Physical Factors
    - Developmental disabilities or other chronic handicaps.
    - Chronic illnesses such as epilepsy or asthma or any current acute illness.
    - Past hospitalizations.
    - Factors that may preclude participation.
    - Eating habits.
    - Any accidents, specifically head injuries or a history of any fainting spells.
    - Any current medications.
- Behavioral Factors
    - School absences.
    - Activity level.
    - Attention span.
    - Peer and sibling relationships.
    - Tobacco, alcohol and drug use.
- Developmental Factors
    - Neonatal risk factors.

- Developmental milestones.
- Language development.
- Academic achievement.

Physical Examination

A complete physical examination should be performed by a licensed physician or licensed nurse practitioner (directly supervised by a physician) and includes:

- General appearance, demeanor, cooperation.
- Height, weight, nutritional status, skin.
- Posture, gait, flexibility, back for scoliosis.
- Eyes and vision.
- Ears and hearing.
- Nose, mouth, teeth, throat, neck.
- Chest, lungs, heart, blood pressure.
- Abdomen.
- Genitalia, hernia, pubertal status (Tanner stage).
- Extremities.
- Behavior, mental status.

Follow-Up

Effective follow-up requires a knowledge of community health resources, and good communication between school health personnel, parents, health professionals and community agencies.

Evaluation/Reevaluation for Special Education Services

Evaluation:

In Part III, Section 3.3(F)(3), the regulations state:

"The LEA shall establish procedures to ensure that each child is assessed in all areas related to the suspected disability, including, where appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities. However, the hearing of each handicapped child shall be tested during the eligibility process prior to placement in a special education program. A complete audiological assessment, including tests which will assess inner and middle ear functioning, must be performed on each child who fails two hearing screening tests. The second hearing test shall be completed not less than 15 nor more than 45 calendar days after administration of the first screening test."

Additional information about evaluation for special education can be found in Part III Section 3.3(F)(5) of the regulations as follows:

"The LEA shall establish procedures to ensure that eligibility for special education and related services is determined with 65 administrative working days after request for such services by the child study committee to the special education administrator."

Reevaluation:

Information about reevaluation for special education can be found in Part III Section 3.4(A)(6) of the regulations (amended August 1, 1991) as follows:

"Each LEA shall ensure that an evaluation of the child, based on required procedures, is conducted:

a. Every three years, or more frequently if conditions warrant;

b. If the child's parent or teacher requests an evaluation; or

c. Anytime a significant change in placement is being considered and the evaluation is not current.

A full reevaluation in all areas related to the suspected disability must be conducted (1) every three years; (2) if conditions warrant a full reevaluation at an earlier date; or (3) if the child's parent or teacher requests a full reevaluation. A full reevaluation need not consist of all of the same assessments conducted during the initial evaluation as long as the reevaluation includes assessment in all areas related to the suspected disability. If three years have not elapsed and the parent or teacher requests that only specified areas be addressed by additional evaluation, and conditions do not warrant a full reevaluation or an assessment which is more comprehensive than that requested by the parent or teacher, the LEA may limit the assessment to those areas in which the parent or teacher requested.

d. Notice is required for the triennial evaluation. Notice and consent are required for those evaluations requested by the LEA other than for triennial evaluations."

Additional Information

Assessment Components:

Additional information about the assessment components for special education can be found in Section 3.3(G) of the regulations as follows:

"Assessment Components

The eligibility of children for special education programs and related services shall be based upon formal assessment involving the components as follows:

1. Educational: written report describing current educational performance and identifying instructional strengths and weaknesses in academic skills and language performance.

2. Medical: written report from a licensed physician indicating general medical history and any medical/health problems which may impede learning.

3. Sociocultural: written report from a qualified visiting teacher or school social worker which describes family history, structure and dynamics; developmental and health history; and social/adaptive behavior in the home, school, and community. The information is obtained through interviews with parents or primary caretakers in addition to use of other social appraisal methods.

4. Psychological: written report from a qualified psychologist based on the use of a battery of appropriate instruments which shall include individual intelligence test(s), and psychoeducational tests.

5. Developmental: written report of assessment of how the child functions in the major areas of development such as cognition, motor, social/adaptive behavior, perception, and communication, where required in the regulations for assessing the specified handicapping conditions.

6. Other, such as speech, language, clinical/psychiatric, etc., where appropriate and/or necessary. Minimum assessment components shall be completed by qualified professional(s) prior to review by the eligibility committee for children suspected of being handicapped in one or more of the following areas (these requirements are also applicable when the triennial review is conducted):

   a. Mentally retarded--psychological, medical, sociocultural and educational/developmental.

   b. Learning disabled--educational, medical, sociocultural, and psychological; observation of academic performance in regular classroom by at least one team member who is knowledgeable about learning disabilities other than the child's regular teacher (or in the case of a preschool or out-of-school student, the observation shall be made in an appropriate environment.) A multidisciplinary team may determine that a child has a specific learning disability if:

      (1) the child does not achieve commensurate with his or her age and ability levels in one or more of the areas listed in above paragraph, when provided with learning experiences appropriate for the child's age and ability levels; and,

      (2) the team finds that a child has a severe discrepancy between achievement and intellectual ability in one or more of the following areas: oral expression, listening comprehension, written expression, basic reading skill, reading comprehension, mathematics calculations, or mathematics reasoning. The multidisciplinary team may not identify a child as having a specific learning disability if the severe discrepancy between ability and achievement is primarily the result of:
         (a) a visual, hearing or motor handicap;
         (b) mental retardation;
         (c) emotional disturbance; or,
         (d) environmental, cultural, or economic disadvantages.

   c. Seriously emotionally disturbed--educational, medical, sociocultural, and psychological.

   d. Hearing impaired--medical (to include complete audiological assessment which will assess inner and middle ear functioning), educational, sociocultural, and psychological.

   e. Visually impaired--medical (to include examination by an eye specialist), educational, sociocultural and psychological.

f. Orthopedically impaired--medical (to include evaluation(s)/prescription(s) for occupational therapy and/or physical therapy when appropriate), educational, sociocultural and psychological.

g. Other health impaired--medical (with special examination reports as appropriate), educational, sociocultural and psychological.

h. Severely and profoundly handicapped - medical (to include evaluation(s)/prescription(s) for occupational and/or physical therapy when appropriate), educational/developmental, sociocultural and psychological.

i. Speech or language impaired--speech and language, hearing screening, educational and other reports as appropriate. An audiological assessment must be performed on each child who fails two hearing screening tests. When the child has not made satisfactory progress after receiving two years of speech services a comprehensive assessment must be completed which consists of the following: medical, sociocultural, psychological and educational.

j. Preschool--medical, sociocultural, developmental and psychological.

k. Autism--medical (with special examination reports as appropriate), educational/developmental, sociocultural, speech and language and psychological.

l. Multihandicapped--medical (with special examination reports as appropriate), educational, sociocultural, and psychological.

m. Deaf/Blind--medical (to include complete audiological assessment which will assess inner and middle ear functioning and examination by an eye specialist), educational, sociocultural, and psychological."

Reference

Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia, July 1, 1990, Amended August 1, 1991.

VOCATIONAL/TECHNICAL MEDICAL ASSESSMENT

Legal Basis

Certain vocational training programs may have health requirements that were established to minimize transmission of communicable disease in the work setting.

Examples:

Program	Health Requirements	Resources
Cosmetology	Tuberculin skin test	Health Dept., Private Physician
Licensed Practical Nursing, Emergency Medical Technical	Tuberculin skin test, Hepatitis vaccine	Health Dept., Private Physician
Horticulture	Tetanus vaccine	Health Dept., Private Physician
Dental Assistant	Tuberculin skin test, Hepatitis vaccine	Health Dept., Private Physician

Recommendation

Each school division should ascertain the requirements for its own vocational programs; students should be counseled about these requirements and available community resources for meeting them. It is recommended that documentation of counseling be maintained in the student's file.

IMMUNIZATION REQUIREMENTS

Legal Basis

Code of Virginia Section 22.1-271.2. Immunization requirements.

Code of Virginia Section 32.1-46. Immunization of children against certain diseases.

Code of Virginia Section 32.1-47. Exclusion from school of children not immunized.

Excerpts:

See Section VI. of this document, Code of Virginia: Attendance Requirements.

Regulations for the Immunization of School Children, Commonwealth of Virginia, State Board of Health. Please refer to the most recent edition of this publication.

Rationale

Immunization requirements were developed to ensure that children entering school have received the vaccines necessary to protect them from certain immunizable diseases and to provide protection for those children who cannot be immunized because of medical or religious reasons.

Standard

Before entering a public school [preschool; Family and Early Childhood Education (Head Start Programs); and grades K-12], every student shall submit documentary proof of immunization to the admitting official of the school, certifying that the student has been immunized against communicable disease or has begun receiving the first series of all such vaccinations.

Minimum Requirements

Minimum immunizations required of new students by the State Board of Health as a prerequisite for school attendance:

DTP: THREE (3) doses of DTP with one (1) of the three (3) administered after the fourth birthday.

If any of these three doses must be administered on or after the seventh birthday, ADULT Td should be used instead of DTP.

OPV: THREE (3) Doses of trivalent OPV with one (1) of the three (3) administered after the fourth birthday

or

THREE (3) doses of eIPV with one (1) of the three (3) administered after the fourth birthday.

MEASLES: TWO (2) doses of live virus measles (rubeola) vaccine, one (1) dose given at 12 months of age or older and a second dose administered prior to entering KINDERGARTEN of first grade, whichever occurs first, effective JULY 1, 1991.

Note: Students enrolling in sixth grade on and after July 1, 1992: TWO (2) doses of live measles vaccine, with the first dose administered at 12 months of age or older and the second dose at least one month later.

RUBELLA: ONE (1) dose of rubella vaccine received at 12 months of age or older.

MUMPS: One (1) dose of mumps vaccine received at 12 months of age or older for students entering school on or after AUGUST 1, 1981.

Abbreviations:

DTP = Diphtheria, Tetanus, and Pertussis Vaccine

OPV = Oral Polio Vaccine

eIPV = enhanced-potency Inactivated Poliomyelitis Vaccine

Evidence of Immunization

The following evidence is acceptable for proof of required immunizations and must include the month, day, and year each dosage was administered. All students for whom dates cannot be provided (month, day, year) must be referred to the local health department or their private physicians to update their records before entering school.

- The School Entrance Physical Examination and Immunization Certification form:
    - Form MCH-213B, provided current immunization requirements have been met (pre-school examinations conducted on or after October 1, 1992, must be documented on Form MCH-213C).
    - Form MCH-213C.
    - A computer-generated facsmilie of Form MCH-213C.
    - The MCH-213C Supplement (the Virginia Department of Health's computerized record of immunizations) indicating the dates of administration of the required vaccines.

Note:

In addition to above acceptable documents, the following are acceptable documents for transfer students:

- A copy of a certificate of immunization from a health department or health organization, military card, health card, or overseas travel card, including month, day, and year each dosage was administered.
- A signed statement from a physician including the month, day, and year each dosage was administered.
- An official school record indicating the month, day, and year each dosage was administered (phone verification of immunizations, including specific dates from another school with records to follow may be used provisionally).

Conditional Enrollment

A student may be enrolled for a period of 90 (ninety) school days contingent upon the student's having received at least one dose of each of the required vaccines and the student possessing a plan, from a physician or local health department, for completing his or her immunization requirements within the ensuing 90 days. The appointment date on the plan will serve as the suspension date if the student fails to keep the scheduled appointment. This process is continued until complete immunization status is attained.

Exemptions

Medical:

A child with a medical contraindication to one or more vaccines may be exempt. The parent or guardian must present a statement on the MCH-213C form from a licensed physician or local health department official that the physical condition of the child is such that the administration of one or more of the required immunizing agents is contraindicated and whether the condition is permanent or temporary. If the condition is temporary, the vaccine must be received within thirty (30) days of the exemption expiration date.

Religious:

A child's parent/guardian may claim exemption for religious reasons by signing the Certificate of Religious Exemption form (Form CRE-1). If the parent maintains the need to continue the religious exemption during a documented school health emergency, the student will be excluded from school for his or her protection until the emergency is concluded.

Please see Section VIII. of this document, Virginia Forms, for a copy of the most recent CRE form.

Reporting Requirement

Each school principal is required to submit an annual summary report to the Virginia Department of Health using the most recent edition of the Student Immunization Status Report form (Form SIS-1).

Please see Section VIII. of this document, Virginia Forms, for a copy of the SIS form.

Recommendation

School Nurse Responsibilities

School nurses are assigned the following responsibilities for assuring immunization compliance in assigned school(s):

- Establishing a system of documenting immunization compliance on the School Health Record.

- Acting as the principal's designated official in issuing special exemptions. The school nurse:

    - Issues special exemption certificates.

    - Maintains tickler file on all Special Exemption certificates issued.

    - Monitors status to assure legal compliance with the immunization law.

    - Documents status on receipt of valid Certificate of Immunization.

    - Reports to principal any students who fail to provide required documentation and must be suspended from school until this requirement is met.

- Maintains liaison with local health department immunization representative.

Compliance

Representatives of the state health department are authorized to audit school records to insure compliance with the regulation. A minimum of 10 percent of the state's public schools are selected from a random sample for annual audit.

Resources

Although these guidelines are designed to cover most situations, there may be individual records and incidents when school personnel may wish to consult with the local or State Health Department. Please contact either:

- The local health department; or,

- The Virginia Department of Health, Division of Communicable Disease Control, Immunization Program.

SCREENING

FINE/GROSS MOTOR SCREENING

Legal Basis

Regulations Governing Special Education Programs in Handicapped Children and Youth in Virginia, Effective July 1, 1990; Amended August 1, 1991.

Excerpt:

" All children (through grade three), within 60 administrative working days of initial enrollment in public schools, shall be screened for fine and gross motor functions to determine if formal assessment is indicated."

Recommendation

Purpose

Basic gross and fine motor screening is crucial in determining if the student is developing within the "normal range." The five areas that need to be screened to ensure normal development include; balance, bilateral coordination, upper extremity coordination, visual motor control, and upper extremity speed and dexterity. Fine and gross motor skills are essential building blocks to educational success.

The screening also allows the parents and administrators to be notified when any student shows signs of a significant impairment that should be followed up by a physician. It also gives information to teachers and parents regarding delays in development of gross and fine motor skills of the child.

If the student fails screening, referral is made to the Child Study Committee for recommendations for further evaluation.

Follow-up

It is important to document the fact that a student has difficulty in a particular area of the screening or fails the screening. The administration needs to be involved with the parents/guardians in helping the student.

Procedure

Materials:

The following materials are used for the K-3 screening:

- 1 playground ball (8 1/2 inch)
- 1 playground ball (4 or 5 inch)
- 1 piece of paper with a circle
- 1 piece of paper with a curved path that is 3/4 inch wide
- 1 pegboard
- 10 small pegs
- 1 stopwatch

Criteria:

The criteria for failing the fine and gross motor screening: the student must fail two out of the three gross motor sections and both of the fine motor skills. The evaluation sheet should have two sections; one for comments and one for pass/fail. The student is allowed two attempts to pass each skill.

Gross Motor Skills:

- Balance

The student fails this section if he or she is unable to perform the following: Kindergarten--alternating, holds left and right foot off ground for 5 seconds; 1st and 2nd grade--10 seconds; 3rd grade--12 seconds.

If the student does not demonstrate the following, comments should be noted: hands on hip, standing still, leg is at 90-degree angle with foot in back and standing tall (no more than 10-degree bend.)

- Bilateral Coordination

The student fails this section if unable to perform the following: Kindergarten, 1st and 2nd grade--jumps in air and claps hands five times consecutively while in air; 3rd grade--jumps in the air and touches both heels with both hands two out of three trials.

Comments should be noted if the student does not perform the following; smoothly integrated claps with the jumps, overflow reactions in facial features.

- Upper Extremity Coordination

The student fails this section if unable to perform the following: Kindergarten and 1st grade--tosses an 8 1/2 inch playground ball in the air and catches it five consecutive times, ball must leave hands and may be trapped in the body; 2nd and 3rd grade--tosses a 4 to 5 inch ball into the air and catches with hands only, five times consecutively.

Comments should be noted if the following are not performed: ball does not go above the head, student stays stationary to catch the ball, ball is tossed straight in the air.

Fine Motor Skills:

- Visual Motor Skills

The student fails this section if unable to perform the following: Kindergarten--copies the circle and makes predominantly circular lines; 1st-3rd grade--draws a line within a curved path and does not make more than two deviations from the curved line.

Comments should be noted if the student does not perform the following: proper pencil grasp, paper is not rotated, pencil stays on paper while duplicating the circle or path.

- Upper Extremity Speed and Dexterity

The student fails this section if unable to perform the following: Kindergarten--places 5 pegs, with one hand, into a pegboard within 30 seconds; 1st and 2nd grade--places 5 pegs, with one hand, into a pegboard within 20 seconds; 3rd grade--places 5 pegs, with one hand into a pegboard within 15 seconds.

Comments should be noted if the student does not perform the following: picks up one peg at a time, does not drop the pegs, pegboard is stabilized with one hand, proper pincer grasp on the pegs.

Summary of Fine/Gross Motor Screening

Gross Motor Functions:

Skill	Grade	Screening Test
Balance	K	Balance on each foot for 5 seconds.
	1 - 3	Balance on each foot for 10 seconds.
Bilateral Coordination	K - 3	Jumping up and down on two feet and landing on both feet while clapping hands.
Upper Extremity Coordination	K - 3	Toss and catch ball or bounce and catch, five times.

Fine Motor Functions:

Skill	Grade	Screening Test
Visual Motor Control	K	Copy a circle (see Figure 1).
	1 - 3	Draw a line within a curved path (see Figure 2).
Upper Extremity Speed & Coordination	K - 3	Sort cubes or pegs; or, string beads.

Figure 1

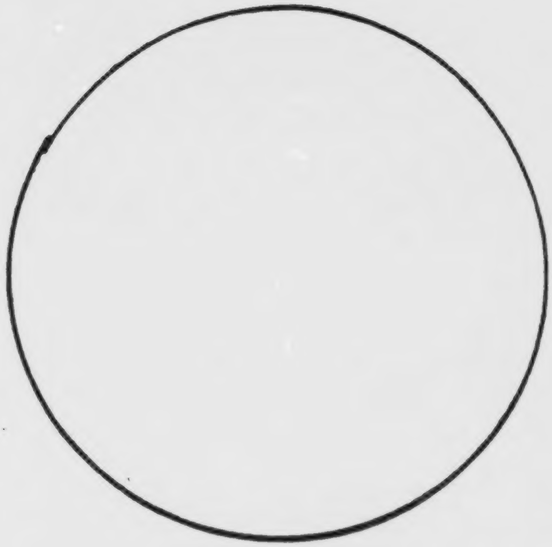
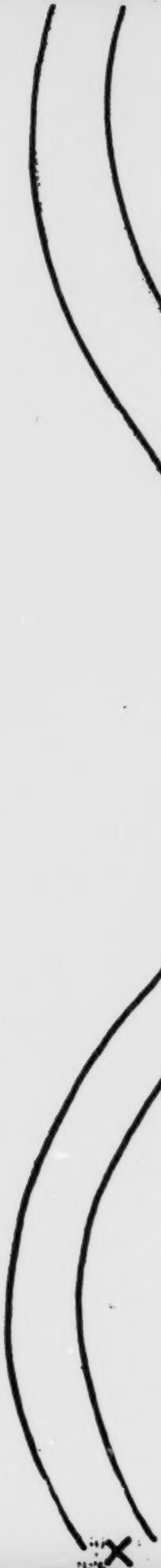


Figure 2



SPEECH AND LANGUAGE SCREENING

Legal Basis

Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia, Effective July 1, 1990; Amended August 1, 1991.

Excerpt:

" All children, within 60 administrative working days of initial enrollment in a public school, shall be screened in the following areas to determine if formal assessment is indicated: (1) Speech, voice, and language; ...."

Recommendation

Rationale

This screening process is a mechanism to identify students, birth through 21 inclusive, who may be in need of special education services.

Procedure

Screening should include the areas of speech (i.e., articulation, voice, fluency), and language (receptive and expressive). The local education agency (LEA) determines who is responsible for the speech-language screenings. Best Practice would indicate that screening of early childhood and elementary students should be done by a speech-language pathologist or under that person's supervision and that the screening of middle and high school students may be done by a teacher, guidance counselor or school nurse. If the LEA designates someone other than the speech pathologist to implement speech-language screening, in-service training by the speech-language pathologist should be conducted.

Referral

If the student fails the screening, referral is made to the principal or designee.

Forms

Several standardized screening instruments are commercially available. The speech-language pathologist serving the LEA can provide further information regarding commercially available screening instruments.

Please see the following sample screening forms:

- Speech-Language Kindergarten Screening
- Speech-Language Screening: Grades 1-5
- Speech-Language Screening Checklist: Grades 6-12

Date: SAMPLE

SPEECH-LANGUAGE KINDERGARTEN SCREENING

NAME: ____________ TEACHER: ____________ SCHOOL: ____________

I. ARTICULATION: Say the following words asking the student to imitate them. Write exactly what the student says.

MOM _____
POP _____
WON _____
BIB _____
NINE _____

DAD _____
TOOT _____
GAG _____
COKE _____
FIFE _____

VALUE _____
LITTLE _____
JUDGE _____
SHUSH _____
CHURCH _____

ZOOS _____
SIS _____
RARE _____
THIRTEEN _____
SPRING _____

II. LANGUAGE

A. Body Parts (Criterion: 5/6)

Show me your:
Head __ Arm __ Knee __ Hand __ Shoulder __ Neck __

B. Opposites (Criterion: 2/3)

Brother is a boy, sister is a ______. A turtle is slow, a rabbit is ______.
The sun shine shines during the day, the moon shines at ______.

C. Distinguishes Prepositions (Criterion 3/4)

Put the block:
on the chair _____
under the chair _____
in front of the chair _____
beside the chair _____

D. Verbal Expression and Reasoning (Criterion 3/3)

What do you do when you are tired? ____________
What do you do when you are hungry? ____________
What do you do when you are cold? ____________

E. Function (Criterion 4/5)

What do you do with:
a cup ____________
a shovel ____________
a brush ____________
scissors ____________
a pencil ____________

F. Observations

☐ Voice Quality--Comments: ____________

☐ Stuttering --Comments: ____________

☐ Intelligibility --Comments: ____________

RETURN THIS SCREENING FORM TO: ____________

SAMPLE

SPEECH-LANGUAGE SCREENING
Grades 1-5

NAME ____________________ AGE __ GRADE ___ DATE ___________

SCHOOL ____________ TEACHER ___________ EXAMINER ___________

ARTICULATION

Ask the child to repeat the following sentences. Circle the words that the child mispronounced.

1. Today Pete's job was to bake a cake for Kurt.
2. Suzie repaired five television sets.
3. Push the garage door closed.
4. George is watching the magic show.
5. We will ride with Lucy to the yellow house.
6. Nancy found some hangers in my brown bag.

LANGUAGE

For grades 1-5: Engage the student in a conversation and note his use of language, articulation, fluency and voice. Things that you can ask to elicit speech are:

"Why did your family move to _____________?"

"How is your other school like (different from) this new school?"

"Tell me about your family, hobbies."

LIKENESSES AND DIFFERENCES

For grades 3-5:
For each pair, tell one way they are alike and tell one way they are different:

watch---clock (L)
bus------train (D)

FOR GRADES 1-2: Using the attached page with pictures depicting a story, ask the student to retell the story in sequence.

___ Child can retell the story in sequence.

___ Child can tell the main idea in each picture.

___ Child responds appropriately to reasoning questions.

"What do you think happened next?"
"Why did his Mom put the cookies up so high?"
"Does he get the cookies? Why or Why not?"

SENTENCE FORMATION

For grades 3-5:
Make a sentence with the following words. Write exactly what the student says.

was: ____

behind: ____

him: ____

if: ____

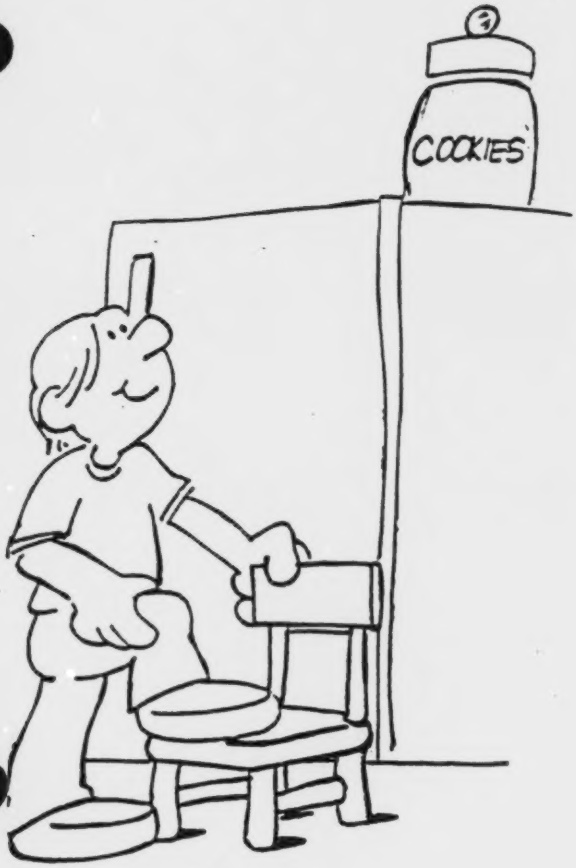
OBSERVATIONS

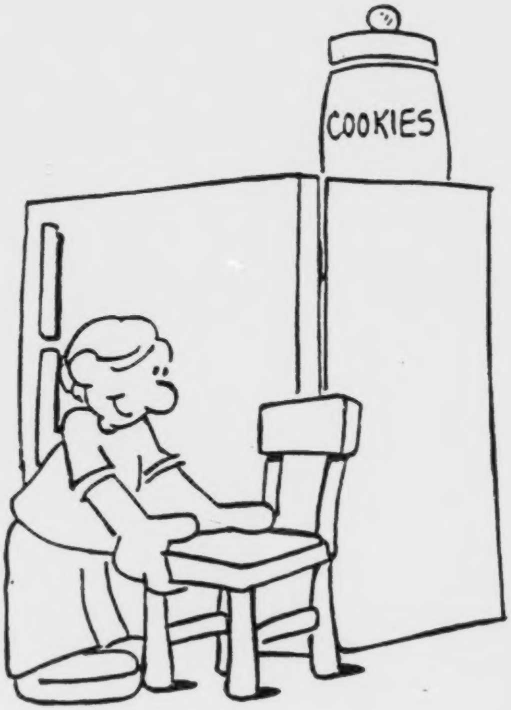
☐ Voice Quality--Comments: ______________________________

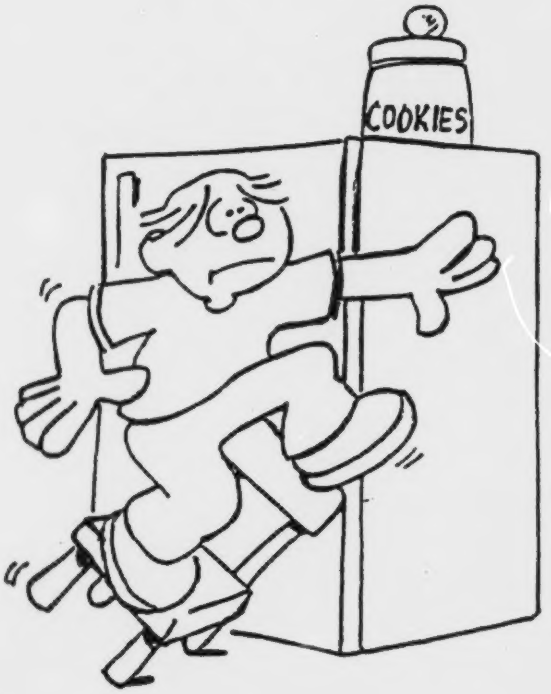
☐ Stuttering --Comments: ______________________________

☐ Intelligibility --Comments: ______________________________

RETURN THIS SCREENING FORM TO: ______________________________







Do you see the cookies right here? (Point to the cookies.) Well, this boy did, too. So he got a chair and put it next to the refrigerator. Then he climbed on the chair, watching those cookies all the time. OOPS! The chair turned over and the boy started to fall!

SPEECH-LANGUAGE SCREENING CHECKLIST

SAMPLE

Grades 6-12

Student's Name ______________________ Date __________

DOB ___/___/___ Age _____ School ______________________

Student's Counselor ______________________ ID# __________

Homeroom Teacher ______________________ Date Entered School __________

This checklist is to be completed for every student who is new to this school by the student's Language Arts teacher.

This student has been ridiculed by his/her peers for (specify): ______________________

	F	O	N	N.O.
This student avoids talking in class.				
This student appears frustrated when trying to talk.				
This student avoids talking to peers/adults.				
This student seems concerned about his/her speech.				
This student withdraws from group activities.				
I feel uncomfortable when trying to communicate with this student.				

Academic:

This student is experiencing difficulties with:

	F	O	N	N.O.
Listening skills				
Concept work				
Following directions				
Oral reading				
Reading comprehension				

Other (Specify) ______________________

OBSERVATIONS

F: frequently

O: occassionally

not at all

NO: not observed

☐ Voice Quality--Comments: ______________________

☐ Stuttering --Comments: ______________________

☐ Intelligibility --Comments: ______________________

☐ Articulation --Comments: ______________________

RETURN THIS SCREENING FORM TO: ______________________

VISION SCREENING

Legal Basis

Code of Virginia Section 22.1-273. Sight and hearing of pupils to be tested.

Excerpt:

See Section VI. of this document, Code of Virginia: Vision and Hearing Support.

SUPTS. MEMO NO. 159, August 19, 1987, Subject: Procedures for Implementing School Law 22.1-273

Excerpt:

"At its April meeting, the Board of Education established procedures for implementing School Law 22.1-273 **Sight and hearing of pupils to be tested.** A copy of the procedures for implementation is attached.

Because all children are required to have a physical examination when they first enter school, it was determined that this requirement would provide adequate screening for kindergarten students. Therefore, the only health screening required to be done for pupils will be for sight and hearing defects in grades 3, 7, and 10. Schools will continue to use the current HPE-h-8 forms for recording their findings."

Update:

The results obtained from the screening are recorded on the Cumulative Health Record form (CS-1,292).

SUPTS. MEMO. NO. 168, September 2, 1987, Subject: Procedures for Implementing School Law 22.1-273

Excerpt:

"Existing Board of Education regulations as specified in Regulations Governing Special Education Programs in Handicapped Children and Youth in Virginia, September 1984 stipulate that:

> All children, within 60 administrative working days of initial enrollment in a public school, shall be screened in the following areas to determine if formal assessment is indicated: (a) speech, voice, and language; (b) fine gross motor functions; and (c) vision and hearing.
>
> Additional screening for vision and hearing should now occur in grades 3, 7, and 10."

Recommendation

Expanded Screening Programs

Individual school divisions, of course, may exceed the above minimum standards for vision testing in locales where school division resources can provide for additional testing. For example, screening of students in grade 1 is important in identifying vision loss at an early age, providing follow-up for medical assessment and treatment, and (if necessary) providing early individualized educational intervention to students with impaired vision.

Additionally, the maturity that the young student gains from the school experience makes it likely that vision test results are more reliable in grade 1 than the testing completed prior to school entry into kindergarten as required by the School Entrance Physical Examination and Immunization Certification from (MCH 213-C).

As another example, physical changes that occur as part of the normal growth and development process cause vision changes that occur most frequently between grades 4-7. If a school division chooses to go beyond the minimum requirements, additional screening for students in grades 4, 5, and 6 may be very beneficial in the early detection and treatment of visual loss.

For further information on expanded vision screening programs, please refer to the American Academy of Pediatrics and the National Association of School Nurses documents listed at the end of this section, under References.

Rationale

The visual process is the most important mode of learning. Integration of visual and motor skills is essential to the learning process. Consequences of visual loss may be:

- Permanent loss of vision in the affected eye
- Loss of depth perception

- Potential decrease in learning ability
- Potential problems in school adjustment
- Cosmetic defects

A child with impaired vision seldom realizes that he/she does not see very well. Therefore, early identification of vision problems is critical to educational performance.

Purpose

- To identify through mass screening any student with vision difficulty.
- To test further those students who fail the initial screening program.
- Referral and follow-up services.
- Provision for appropriate educational accomplishments for students with vision impairment.

Procedure

Observation:

Vision referral often can be made for the following reasons:

- Redness of the eyelids or conjunctivae.
- Reaction to testing such as squinting, frowning, scowling, puckering of face, or leaning forward.
- Watery eyes.
- Complaints of itching, pain, blurring, or double vision.
- Deviation of the eyes, crossed eyes.
- Poorly fitting glasses or scratched lenses.

Distance Visual Acuity:

Explanation of the test procedures should be given to the class as a group before screening begins, and individually as needed to assure that students understand the procedure.

- Select a room for testing that has diffuse lighting. Be sure that any glare is removed.
- Mark off 20 feet from the Snellen Eye Chart or Tumbling E. Chart, and have the child stand or sit at this line. The line may be marked with masking tape or paper feet placed on the floor so that the child will be on the 20 foot line. (If a 10-foot chart is used, the line should be marked 10 feet away from the chart.)
- Each eye is tested separately, there is no need to test them together. Cover left eye with an occluder, a card, or paper cup and test the right eye. Do not press on the eyeball. Reverse the procedure and test the left eye.
- Instruct student who wears glasses to keep glasses on. Then test both eyes with and without glasses.
- Instruct student to keep both eyes open and read the letter to which you point. (Pointing should be done below the symbol or letter.)
- Do not isolate a single symbol, present one line at a time.
- Failure to read 3 out of 5 or 4 out of 7 symbols on a line requires moving to the line above until vision is established. When testing young children start with the 20/40 line and move down to the 20/30 line. If student is unable to read 20/40 line move upward.
- Record results - If a visual acuity of 20/40 or less is established for either eye, arrange a second screening. Referral should be made if second screening results indicate failure.
- Record screening results on student's permanent health record.

Note:

Vision results are written and spoken of as one number over another - for example, 20/20 vision. The figures refer to the distance at which a standard object can be recognized. A person who is nearsighted (myopia), for example, may only be able to recognize at 20 feet an object that a person with perfect vision can recognize at 100 feet. In this case he is said to have 20/100 vision. The top number recorded refers to the number of feet from the eye chart, and the lower number refers to the line of the chart the student is able to read. If a 20-foot chart is used, the top number is recorded as 20.

Color Discrimination:

Ideally, screening for color deficiency is recommended in the second semester of the first grade because of educational or vocational implications. There is no treatment. Use the following procedure:

- Use Ishihara Test Books.
- Instructions with the test should be followed.
- Test should be used with adequate lighting.

Referral Criteria:

Referral for a professional eye examination should be made for the following:

- Acuity in one or both eyes is 20/40 after the second screening.
- A two-line difference in acuity between the eyes.
- Any of the previously listed conditions noted during observation.

Follow-up:

- A second screening should be done within two weeks to one month when student fails the first screening.
- Parents should be notified in writing of vision problems.
- Teachers should be notified of vision problems.

Reporting Requirements

Please see Section VIII. of this document, Virginia Forms, for a copy of the following forms:

- Summary of Screening of Vision and Hearing: Report to Principal (LF.011)
- Summary of Screening of Vision and Hearing: School Division Report (LF.010)

Resources

- Contact usual provider of care.
- Contact your local chapter of the Lions Club.
- Refer to your local health department.

References

Potter, Diana Odell, Editorial Director. Assessment. The Nurse's Reference Library, Springhouse, Pa.: Inter-Med Communications, Inc.

Children's Eye Health Guide. New York: National Society to Prevent Blindness, 1982.

Infant and Children's Eye Care. American Academy of Ophthalmology.

American Academy of Pediatrics. School Health: A Guide for Health Professionals. Elk Grove Village, Ill.: the Academy, 1987, p. 104.

Vision Screening Guidelines for School Nurses. National Association of School Nurses, Inc.

HEARING SCREENING

Legal Basis

Code of Virginia Section 22.1-273. Sight and hearing of pupils to be tested.

Excerpt:

See Section VI. of this document, Code of Virginia: Vision and Hearing Screening.

SUPTS. MEMO NO. 159, August 18, 1987, Subject: Procedures for Implementing School Law 22.1-273.

Excerpt:

See Section III. of this document, Services: Vision Screening.

SUPTS. MEMO. 168, September 2, 1987, Subject: Procedures for Implementing School Law 22.1-273.

Excerpt:

See Section III. of this document, Services: Vision Screening.

Recommendation

Expanded Screening Programs

Individual school divisions, of course, may exceed the minimum requirements for hearing testing in locales where school division resources can provide for additional testing. For example, screening of students in grade 1 is important in identifying hearing loss at an early age, providing follow-up for medical assessment and treatment, and (if necessary) providing early individualized educational intervention to students with impaired hearing. Additionally, the maturity that the young student gains from the school experience makes it likely that hearing test results are more reliable in grade one than the testing completed prior to school entry into kindergarten as required by the School Entrance Physical Examination and Immunization Certification form (MCH 213-C).

For further information on expanded hearing screening programs, please refer to the American Academy of Pediatrics' and National Association of School Nurses' publications listed at the end of this section, under References.

Rationale

Five to ten percent of the school population do not pass the hearing test; the majority of these students are medically treatable. One percent will show permanent hearing impairment that will require intervention. The most important hearing range for educational and communication purposes is 1000-4000 Hz. The most important effect of a hearing loss is that it creates a language barrier, interferes with communication, and may result in the following problems:

- Delay in normal speech and language.
- Development of abnormal social growth and behavior.
- Lack of educational progress.
- Development of adjustment problems for the child and the family.

Purpose

The purpose of hearing screening is to identify students with hearing losses that may affect their educational, social, speech, and/or language development. A good hearing screening program will incorporate the following objectives:

- Promotion of hearing health.
- Prevention of hearing losses.
- Detection of hearing problems through periodic hearing evaluation.
- Referral and follow-up services.
- Provision for appropriate educational accommodations for students with hearing impairment.

Behavioral Indicators of Hearing Loss

- Recurring middle ear infections or upper respiratory infections.
- Mouth breathing, draining ears, or earache complaints.
- Sudden school failure following a severe illness.
- Frequent requests to repeat what has just been said.
- Irrelevant answers to questions.
- Indistinct speech.
- Watching the lips of the speaker.
- Talking either too loudly or too softly.
- Makes mistakes in following directions and taking dictation.

Procedure

The pure tone audiometer is the preferred equipment to use in school hearing screening. This machine should be calibrated at least once a year. Following is the test procedure:

- Turn machine on and listen to screening tones to assure that audiometer is properly functioning.
- Give careful directions to the students before beginning. This may be done individually or to the entire class. Be sure they understand to raise their hands the minute they hear the sound.
- Select a room in the quietest part of a building. A sound-proof room is not necessary.
- Place earphones on each ear (red on right ear, blue on left ear). Be sure that earphones fit snugly and that nothing interferes with the passage of sound.
- Be sure that students are not chewing food, candy, or gum.
- Set the Hearing Threshold Level at 25 dB and the frequency at 2000 Hz.

- Present the tone (2000 Hz) for one to two seconds. Right ear first. Tone may be presented twice to make sure the child hears the tone and understands what is supposed to be heard.
- Proceed to 4000 Hz, then to 1000 Hz and on to 500 Hz.
- Repeat the procedure in the left ear. Vary the length, tone, and pauses to prevent establishing a rhythm.
- If the student fails to hear any tone, it may be repeated at the same level.

Follow-up

- A student who fails to respond in either ear to two or more frequencies should be retested within a two-week period.
- Students who fail retesting should be referred to an audiologist, family physician, or local health department.
- Teachers should be notified if the student needs preferential seating in the classroom.

Reporting Requirements

Please see Section VIII. of this document, Virginia Forms, for a copy of the following forms:

- Summary of Screening of Vision and Hearing: Report to Principal (LF.011)
- Summary of Screening of Vision and Hearing: School Division Report (LF.010)

Resources

- Refer to your local health department or private physician.

References

- Hearing Screening Guidelines for School Nurses. National Association of School Nurses, Inc.
- American Academy of Pediatrics. School Health: A Guide for Health Professionals. Elk Grove, Ill.: the Academy, 1987, p. 105.

SCOLIOSIS SCREENING

Legal Basis

There is no legal requirement to provide scoliosis screening; however, the Board of Education has encouraged scoliosis screening as indicated in the following memorandum:

SUPTS. MEMO NO. 159, August 18, 1987, Subject: Procedures for Implementing School Law 22.1-273: Attachment.

Excerpt:

"Practices That Are Encouraged:

...That scoliosis screening be done for all students in grades 5 through 9."

Recommendation

Screening Program

Scoliosis screening is recommended annually for students in grades 5 through 9 (ages 10-15).

Rationale

Scoliosis is an abnormal curvature of the spine. The purpose of screening is to detect scoliosis at an early stage when treatment can be most effective in preventing the progression of the disease. If untreated, the curvature of the spinal cord may progress and impair the body's range of motion and endurance, distort the position of the ribs, and impair the normal function of the heart and lungs. The person is more susceptible to many diseases and life expectancy is decreased.

Progressive curves occur three or four times more frequently in girls than in boys. Scoliosis tends to run in families, and if scoliosis is diagnosed, other siblings should be evaluated.

The prevalence of scoliosis begins to increase at about age 10-11 with the pre- adolescent growth spurt. A spinal curve may go undetected until a significant deformity has occurred. There are several reasons for this:

- Routine physical exams are infrequent, since this is a relatively healthy period of life.
- This age group typically exhibits slouching, round-shouldered posture.
- Parents rarely see their children without clothing because of adolescent modesty.

Therefore, screening through the schools is an effective means of reaching the population at risk.

Procedure

Prior to screening:

- A training session should be provided to screeners prior to screening. School nurses have the responsibility for organizing and implementing the scoliosis screening program collaboratively with P.E. teachers. If a school nurse is unavailable, screening can be done by other licensed health professionals (e.g., physicians, nurses or physical therapists who have been trained in scoliosis screening technique).
- The school division may send a letter to parents that explains the screening. Please see end of this section for a sample explanation/permission letter to parents from the school
- Students should receive classroom instruction including: what scoliosis is, how it is detected, why it is important to screen, what the screening procedure will be, and what will be done for those with positive findings.

Screening:

Boys and girls must be screened separately in an area that accommodates the need for privacy. It is recommended that students wear gym clothes. Boys should strip to the waist and girls should wear bra or halter/bathing top. Shoes must be removed.

- Student should stand erect (e.g., shoulders back, head up, gaze ahead, hands hanging at side, knees straight and feet together), stands 5-8 feet away with back to the screener who checks for the following:
    - ○ Unequal shoulder blades.
    - ○ One shoulder blade protruding more or higher.
    - ○ Uneven or greater crease at one side of waist.

  - Unequal distance between arms and body and apparent unequal length of arms as arms hang straight down from side.
  - Obvious lateral curvature of the spine.
  - Unequal hip level.

- Screener views student from the side for:
  - Increase in the normal curve of the thoracic spine (kyphosis).
  - Increased curve in the lumbar area, swayback (lordosis).
- Student bends slowly forward (back to screener) 90 degrees from waist; feet together, arms straight and hanging, with palms together. Screener checks for:
  - Thoracic rib prominence - one side of the rib cage is higher than the other.
- Student faces screener, bends slowly forward 90 degrees at waist, feet together, arms hanging in front, palms together, knees straight. Screener checks for:
  - Thoracic rib prominence.
  - Asymmetrical level of two sides of the back.
  - Lumbar prominence.

Using Scoliometer:

- View the student from behind, while he or she is standing erect.
- Ask the student to extend his or her arms forward and place hands together with palms flat against each other, as if preparing to dive into water.
- Ask the student to bend forward slowly, stopping when the shoulders are level with the hips. View the student from both the front and the back. For best view, the eyes of the examiner should be at the same level as the student's back. Note any rib elevation and/or asymmetry in the flank (low back) area.

- Before measuring with the scoliometer, adjust the height of the student's bending position to the level where the deformity of the spine is most pronounced. This position will vary from one student to another depending upon the location of the curvature. For example, a curve low in the lumbar spine will require that the student bend further forward than if the curve is present in the thoracic or upper spine.

- Lay the scoliometer across the deformity at right angles to the body, with the "o" mark over the top of the spinous process. Let the scoliometer rest gently on the skin; do not push down. Read the number of degrees of rotation.

- Note: If there is asymmetry in both the upper and lower back, two scoliometer readings will be necessary. The curves will almost always go in opposite directions with the one in the thoracic spine usually to the right and the other in the lumbar spine usually to the left.

- The screening examination is considered positive if the reading on the scoliometer is 5 degrees or more at any level of the spine. Students in this category should be referred immediately for further medical evaluation. Lesser degrees of rotation may or may not indicate a mild degree of scoliosis. Immediate referral is not necessary; however, in such cases, rescreening is recommended within three to six months. Consult your local medical advisor to the program for details.

Referral Criteria:

Refer all children with observable findings for re-screening and further assessment using the screening procedure worksheet to help in the identification process.

Rescreening

All students with observable findings on initial screening should be rescreened individually by the nurse or school physician to validate findings before a referral is made.

Referral Criteria:

Referrals for further evaluation by the family physician, pediatrician, or orthopedic surgeon should be made on all students who are found to have:

- A rib hump - moderate to severe (greater than 1 cm in height).

- A curve of the spine, lordosis or kyphosis.

- Two or more of any of the other signs: shoulder elevation, uneven shoulder blades, uneven hips, unequal arm to body spacing, uneven waist creases.

Students with minimal findings should be rescreened in four to six months.

Follow-up:

- Explain to student the significance of the screening without causing undue anxiety and apprehension.

- Notify parents to explain findings and recommend that student be examined by the family physician, pediatrician, or orthopedic surgeon. Emphasize that this is not an emergency. Please see end of this section for a sample referral letter.

- The information contained on the Scoliosis Screening Report form is used to provide a source of documentation for follow-up purposes. Please see Section VIII. of this document, Virginia Forms, for a copy of the form.

NORFOLK PUBLIC SCHOOLS

____

Date

Dear Parents of Fifth Grade Pupils:

In the next few weeks, the Norfolk Public Schools and the Norfolk Health Department will conduct a Scoliosis Screening program to find the children who have abnormal curvatures of the spine. According to current medical information, scoliosis most commonly occurs in children in the 9 to 14 year age group. Seven to ten of every hundred children may develop some degree of scoliosis and one to three of this group may require treatment. If the condition is detected early and appropriately treated, progessive deformity of the spine can be prevented, and the child can be protected from the emotional and physical pains of deformity. The procedure for screening is a simple one in which the screener, the School Health Nurse, looks at the child's back while he or she is standing or is in the forward bending position. The proper screening procedure is shown on the back of this letter.

If your child has a possible abnormal curvature, you will be notified and asked to take your child to your family physician, pediatrician, or orthopedist for diagnosis. If you should receive such a notice, you should take your child to the doctor as soon as possible; delay could result in the need for an operation.

You must return the bottom portion of this letter indicating your approval or disapproval of your child's participation.

Sincerely yours,

Superintendent of Schools

Director
Norfolk Health Department

THIS FORM MUST BE RETURNED TO THE SCHOOL OFFICE THE DAY AFTER RECEIPT.

NORFOLK PUBLIC SCHOOLS
NORFOLK HEALTH DEPARTMENT

I [ ] do want my child

I [ ] do not want my child

__________________________, __________, to participate in the curvature of the
Name Age

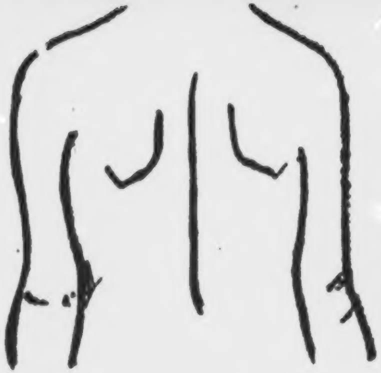
spine screening program.

____
Signature of Parent or Guardian

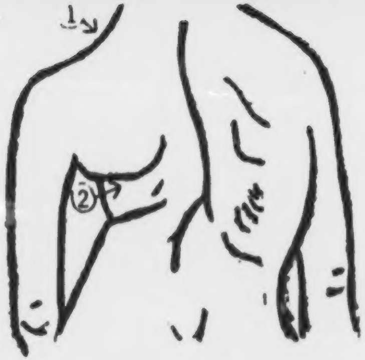
Telephone: ________________ Address: ______________________

SCHOOL ADMINISTRATION BUILDING, POST OFFICE BOX 1357, NORFOLK, VIRGINIA 23501

STEPS TO CHECK YOUR CHILD BY



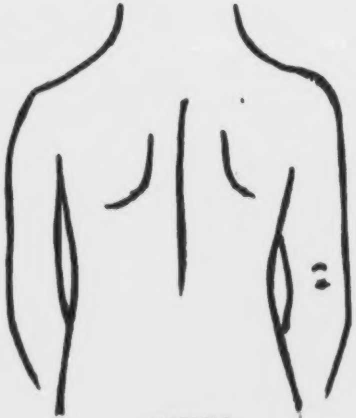
NORMAL



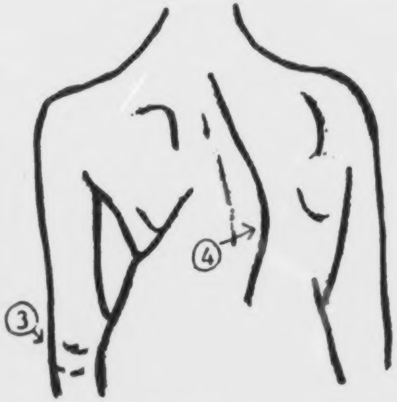
ABNORMAL

1. Are the shoulders even?

2. Do the shoulder blades appear even?



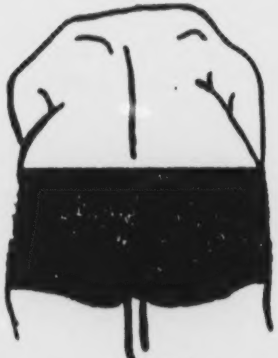
NORMAL



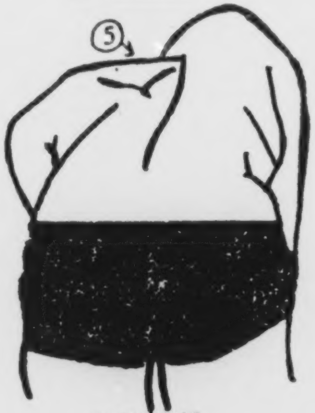
ABNORMAL

3. Do the arms hang even?

4. Is the backbone straight?



NORMAL



ABNORMAL

5. On bending over, is the back even?

A "NO" answer to any of the above should urge you to have your chil screened for scoliosis.

PLEASE KEEP THIS FORM FOR FUTURE REFERENCE

Drawings by Jane Yost, Director of Health Education and Information

SAMPLE

NORFOLK PUBLIC SCHOOLS
NORFOLK PUBLIC HEALTH DEPARTMENT

REFERRAL LETTER--SCOLIOSIS SCREENING Date____________

Dear Parent:

Your child ______________________________ participated in our school scoliosis screening program.

Although the results do not definitely mean that there is a problem or that treatment is needed, you are urged to take your child to your family physician, pediatrician or orthopedist for an examination.

The cause of scoliosis (curvature of the spine) is unknown. It becomes more apparent during adolescence and often can be corrected if discovered and treated early.

Please request the examining physician to complete this form. When your child has completed his/her examination (and you have signed the parent signature line*) please return this referral to the school nurse.

Thank you for your cooperation. Please feel free to call me if you have any questions.

	Poss. Aborm.	Ortho-team Check
1.	________	________
2.	________	________
3.	________	________
4.	________	________
5.	________	________

Sincerely,

School Health Nurse
School:____________________

* * *

PHYSICIAN'S FINDINGS AND RECOMMENDATION:

I have examined ____________________ on ____________________

( ) Standing (anterior-posterior x-ray) shows:____________________

____

( ) No significant findings at this time ____________________

( ) Need for further evaluation ____________________

( ) Re-examination or treatment recommend (if so, Date____________________)

Additional Comments: ____

____

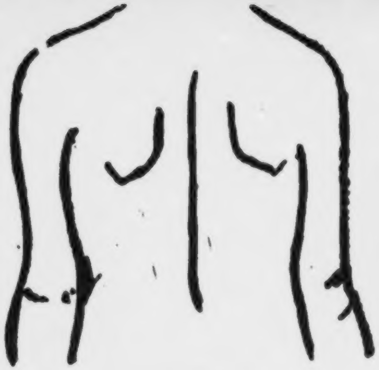
Signed____________________ M.D.

Address____________________

Telephone No ____________________

*____________________
Parent's Signature Line

STEPS TO CHECK YOUR CHILD BY



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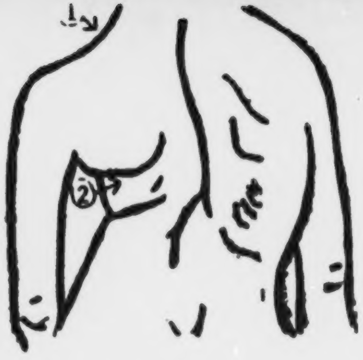
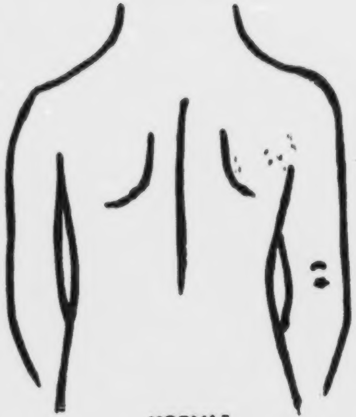


ABNORMAL

1. Are the shoulders even?

2. Do the shoulder blades appear even?



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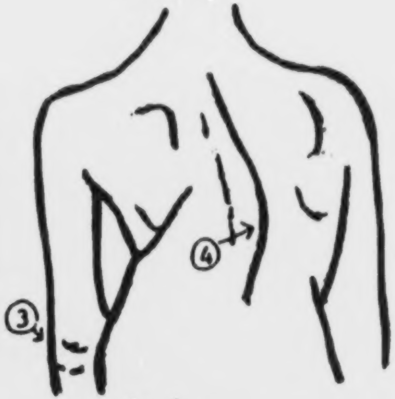
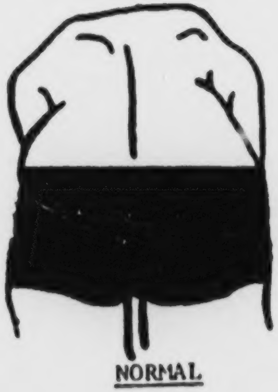


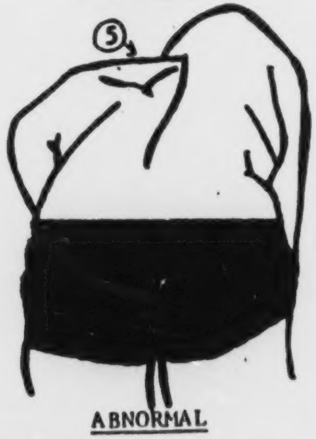
ABNORMAL

3. Do the arms hang even?

4. Is the backbone straight?



NORMAL



ABNORMAL

5. On bending over, is the back even?

A "NO" answer to any of the above should urge you to have your chil screened for scoliosis.

PLEASE KEEP THIS FORM FOR FUTURE REFERENCE

Drawings by Jane Yost, Director of Health Education and Information

DENTAL SCREENING

Legal Basis

While there is not a specific mandate for dental screening, the provision of required health services may involve correction of dental problems that adversely affect a student's health.

Recommendation

Introduction

Oral (dental) health should be an essential part of a school health program. In addition to the dental health curriculum, the school health program should include a safe environment and services that enhance the child's oral health.

The dental health curriculum should promote personal responsibility for one's own oral health. Services, such as a dental screening and the initiation of one of the preventive programs listed later in this section, can provide a head start for good oral health until such time as the child is able to assume full responsibility for his/her actions.

A safe environment can do much to promote good oral health and protect children such as restricting the sale of candy and soft drinks, prohibiting the possession of tobacco products, requiring the use of mouthguards in organized high body contact sports, and designing schools and equipment to lessen the risk of injury.

The National Collegiate Athletic Association has mandated use of mouthguards for football, hockey, men's lacrosse, and women's field hockey. Mouthguards are recommended for basketball and baseball because many orofacial injuries occur in these sports.

Children should be cautioned about running, pushing, and shoving other children. Fractures of the teeth frequently occur at drinking fountains as a result of these activities.

Present Conditions

In spite of all the on-going preventive efforts in Virginia, oral health problems remain among the most prevalent childhood diseases. Virginia statistics indicate that by 5 years of age more than three primary teeth are affected by decay. Dental caries, which is a localized progressive destruction of the tooth, strikes early in life and continues at an accelerating rate throughout childhood and the teen-age years. The average 12-year-old in Virginia has more than three permanent teeth affected by decay. By the age of 17 this average rises to more than six, almost one-fifth of the permanent dentition.

Recent surveys conducted in the state indicate that at any one time over 50 percent of school-age children are in need of treatment due to carious teeth. Less than 60 percent of the decayed teeth are restored. Dental caries can be prevented through the application and practice of effective preventive procedures.

The daily removal of bacterial plaque, the proper intake and application of fluoride, the timely application of dental sealants, restriction in the amount and frequency of the consumption of carbohydrates, and periodic visits to the dentist will effectively prevent or control the majority of dental caries.

Periodontal disease, a major cause of tooth loss among adults, usually begins during the childhood years as inflammation of the gums. While there are no statistics available in Virginia, national figures indicate that 14 percent of children, ages 6-11, have gingivitis and more than 32 percent of children ages 12-17, have the same problem. While the severity of gingivitis is generally mild in the early years, the danger lies in the gradual progression of the disease, which often occurs without definitive symptoms and results in the loss of supporting tooth structures (periodontitis) and eventual loss of teeth.

Periodontal disease can also be prevented through the use of effective procedures. Presently, the prevention and control of gingivitis and periodontal disease can best be accomplished by the daily removal of bacterial plaque and a thorough prophylaxis by the dentist or dental hygienist on a timely basis.

A major problem, however, in preventing these two diseases, is the difficulty encountered in motivating children, their parents, and others to use preventive measures on a routine basis.

While some forms of malocclusion (crooked teeth) are hereditary, certain forms may be prevented by maintaining the primary dentition, the timely placement of space maintainers in the event a tooth is lost, the timely extraction of teeth, or the correction of abnormal oral habits. It is important that the child see a dentist early in life so as to prevent or correct malocclusion.

Accidents involving the mouth and teeth are another concern for school-age children. Statistics from a study conducted in Seattle, Washington, indicate that 8 percent of all school injuries were dentally related. Although the incidence of oral injuries does not appear to be high, the residual treatment needs may be long-lasting and costly. Many oral injuries could be prevented through modification of the environment or use of safety practices. Mouthguards, if not required, should be encouraged for all organized high body contact sports.

The incidence of oral cancer, while not large, is extremely serious because of life-threatening consequences. In the United States there were over 30,000 new cases and approximately 8,500 deaths in 1991. About 75 percent of these cancers are attributable to tobacco and alcohol use. With the increased use of smokeless tobacco, children should be alerted to its potential dangers. Many of Virginia's school systems have in place rules against possession and use of tobacco while on school grounds.

Dental Screening

If children are to maintain optimal oral health, they should have a dental examination on a routine basis. Ideally, the examination should be done at least yearly in the dentist's office. If that is not possible, then less-comprehensive inspections or screenings can be done in the school setting. The screenings should look for the presence of dental caries, periodontal disease, oral hygiene, missing teeth, and bite (malocclusion) problems. Possible signs of dental health problems that one should be alerted to are swollen jaw, poor oral habits such as thumb-sucking, complaints of bleeding or ulcerated gums, toothache, unusual alignment of teeth, complaints of loose teeth, bad breath, and refusal to eat hard foods.

When screenings are completed, parents or guardians should be notified of the findings and follow-up should be provided for children who need assistance. The results of each student's screening should be incorporated into the student's permanent health record.

Please see end of this section for a copy of a suggested form, Report of School Dental Inspection.

Resources

There are many available resources in Virginia to assist school personnel with the dental portion of the school health program.

- Local Health Departments

  Many local health departments provide dental care for pre-school and school-age children. Charges are on a sliding fee schedule based on family income. Children on free and reduced priced lunches are not charged.

  Dental personnel of the local health departments are an excellent resource for consultation, in-service education, screenings, and dental education in the schools.

- Department of Medical Assistance Services (Medicaid)

  Dental care is available through private practitioners and the local health departments for indigent children eligible for Medicaid. Eligibility, based on income and other factors, is determined by the local Department of Social Services. Not all dentists accept Medicaid - so it is best to check with a dentist before referring children for dental care.

- State Health Department, Division of Dental Health

  The Division of Dental Health offers the following services and preventive programs to improve the dental health of children:

  - Fluoridation of the Public Water Supply

    This is the best method available to prevent dental decay in a community. The division will provide funds for any community with a population of more than 800 people to fluoridate the public water supply.

  - Fluoridation of the School Water Supply

    This is another very good measure to prevent dental decay in rural areas that do not have a public water supply.

  - Fluoride Mouthrinse

    This practice, for use in rural areas without fluoridated water, is another excellent method of reducing dental decay. Children rinse for one minute once a week with a diluted fluoride solution. The division will provide all of the materials for the first year and the fluoride rinse for subsequent years. Many rural school divisions in the state use this method in elementary schools.

  - Consultation, Inservice Training, and Educational Materials

    The division will provide consultation on any aspect of oral health and will provide in-service training for teachers and school nurses. Educational materials are also available on a limited basis upon request.

  - Dental Surveys and Screenings

    The division will assist in dental screenings upon request and perform epidemiological surveys to determine the dental needs of a school division.

For further information on any of these services or programs, please contact the Virginia Department of Health, Division of Dental Health, P.O. Box 2448, 1500 East Main Street Station, Room 131, Richmond, Virginia, 23218-2448 or call (804) 786-3556.

- Local and State Dental and Dental Hygiene Societies

Assistance may be obtained from local dental societies or the State Dental Association. Please contact one of the local dentists or hygienists in your community for assistance.

SAMPLE

Chart

(Front) REPORT OF SCHOOL DENTAL INSPECTION

Parent or guardian____

A dental inspection of your child ____________________________ has been made. This inspection shows:

______ 1. Need for dental attention. It is recommended that your family dentist be consulted as soon as possible.

______ 2. No readily apparent dental defects. However, it is recommended that your child visit your family dentist for a more complete examination.

____

Date Signed

(BACK) CERTIFICATE OF DENTAL WORKDONE

This is to certify that the bearer:

______ 1. Has had all necessary dental work completed.

______ 2. Is under dental treatment.

______ 3. Is in need of no denial work at this time.

Further recommendation____

____

____

____

Date Signature of Dentist

Please return this card to the teacher.

BLOOD PRESSURE SCREENING

Legal Basis

While there is not a specific mandate for blood pressure screening, blood pressure measurement may be a component of a required physical assessment. Please see Section III. of this document, Services: Health and Physical Assessment.

Recommendation

Introduction

Blood pressure screening should be conducted on students in grades 7 and 10 in conjunction with health education lessons that identify risk factors associated with hypertension and cardiovascular disease. A health education lesson on blood pressure is also taught in grade 9. Although routine screening is not offered at this grade level, the nurse should be consulted for assistance.

Blood pressure measurement is part of the complete health assessment of any child. The American Academy of Pediatrics recommends that blood pressure measurement be performed at ages 3, 4, 5, 6, 8, 10, 12, 14, 16, 18, and 20+.

School divisions with large numbers of students who do not receive routine primary care may consider implementing a blood pressure screening program going beyond the screenings in grades 7 and 10 that are in conjunction with health education lessons. It is a low yield program, but for the few cases of hypertension discovered, early treatment is beneficial.

All students and staff who have symptoms indicating the need, should have their blood pressure monitored.

Rationale

- Cardiovascular disease is the number one cause of death in the nation.
- Untreated high blood pressure contributes to cerebral vascular accidents (stroke) and heart disease.
- High blood pressure may be an early indication of the presence of other serious health conditions which need further medical evaluation.

- High blood pressure does not usually cause symptoms - most individuals find out they are hypertensive after a blood pressure check
- High blood pressure can be treated with diet, exercise, and medication (or a combination of these) to prevent such complications as stroke and heart attack.
- Blood pressure screening presents an excellent opportunity for health education prevention and health promotion related to cardiovascular health with a population of emerging adults.

Best Practice

- School nurses should have the responsibility for organizing and implementing a blood pressure assessment program which includes screening and education of risk factors associated with hypertension and cardiovascular disease.
- Screening should be conducted in a quiet environment that is free from noise.
- Necessary equipment includes stethoscope and sphygmomanometer (blood pressure measuring instrument) (mercury or aneroid) and correct size cuff - child, adult, large adult.
- Sphygmomanometers should be checked yearly for calibration to ensure their accuracy and reliability.
- The school nurse may elect to do initial screening or monitor and supervise volunteers.
- An individual assessment should be conducted by the nurse for all students with elevated blood pressures.

Procedure

Prior to screening:

- Prepare students for screening activity by explaining procedure to be used.
- Allow sufficient time (5 minutes) before screening procedure to allow students to rest from any physical activity.

- The screening for blood pressure should not be done during or immediately following physical education classes.

Screening:

- Select the appropriate compression cuff: proper cuff size is essential for accurate pressure readings. An oversize cuff may produce an erroneously low reading, whereas an undersized cuff may give an erroneously high result. The cuff used should cover 75 percent of the upper arm but not encroach on the antecubital fossa. The inflatable bladder of the cuff should be long enough to encircle the arm (with or without overlapping). The arm should be bare.

- Palpate the radial pulse while inflating the cuff to estimate the systolic pressure.

- Deflate the cuff slowly to drop at about 2-3 mm Hg/second, listening throughout the entire range of deflation until 10 mm Hg below the level of diastolic reading. Measure from the 1st sound initially heard to the last sound. Intensity and quality of sound varies.

- Record the systolic pressure at the point where the initial tapping sound is heard for at least two consecutive beats.

- In the event the sounds are inaudible, the following action may be taken to augment the sounds.

  - Rapidly inflate the cuff to decrease the amount of blood trapped in the forearm thus increasing the loudness of sounds.

  - Elevate the arm for 30 seconds, inflate the cuff while the arm is elevated, lower the arm to heart level, and deflate the cuff.

  - Instruct the student to open and close the fist rapidly 10 times after the cuff is inflated above systolic level.

- Too much pressure with the stethoscope can compress the artery, therefore the pulse can be heard down to zero.

- Record systolic and diastolic pressures on the student's health record.

- If either the systolic or diastolic reading is higher than normal blood pressure ranges (see Table 3), allow the student to rest about 15 minutes and recheck. All students whose blood pressure is found above the normal ranges are to go to the clinic for further assessment.

- Students referred to the school clinic for further assessment of blood pressure should be referred for medical evaluation based on Table 4 and the Referral Criteria listed below.

Table 3: Normal Blood Pressure Ranges

Age in Years	Blood Pressure Ranges
6 & under	78/48 - 114/80
7 - 9	82/52 - 120/80
10 - 12	90/58 - 134/84
13 - 49	90/60 - 140/90
50 & older	90/60 - 160/95

Table 4: Classification Chart

Age in Years	95th-99th Percentile	99% Percentile
3 - 5	116/76 - 123/83	> 124/84
6 - 9	122/78 - 129/85	> 130/86
10 - 12	126/82 - 133/89	> 134/90
13 - 15	136/86 - 143/91	> 144/92
16 - 18	142/92 - 149/98	> 150/98

Referral Criteria

- Blood pressure referrals for children 3-18 years are made only in accordance with the above classification chart (Table 4). These standards represent the 95th to 99th and 99th percentiles for blood pressure in populations and provide criteria for referral.
- Because of the lability of the blood pressure in children, measurements that are in the 95th-99th percentile should be repeated at least three times at different visits under

circumstances in which apprehension and anxiety are minimized. The average of these three measurements is then used to determine if referral is necessary.

- Immediate referral if child's blood pressure measurement falls in 99th percentile on any single occasion. Serial measurement and medical evaluation should be by the physician.
- Refer all students whose average blood pressure measurement (taken on three different occasions) is between 95th-99th percentile.
- Continued monitoring should be provided when requested by the health care provider or when the need is identified by the school nurse.
- For adults, a referral should be made if the average systolic pressure is over 140 or the diastolic is over 90 when taken on three separate occasions.

Forms/Graphs/Algorithm

Please see the following items at the end of this section:

- Sample Blood Pressure Screening Referral form
- Age-Specific Percentiles of Blood Pressure Measurements graphs (Figures 3-6)
- Algorithm For Identifying Children With High Blood Pressure (Figure 7)

References

Report of the Second Task Force on Blood Pressure Control in Children. U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, January 1987.

School Health Program Manual. South Carolina Department of Health and Environmental Control, 1990.

Newton, Jerry, M.D. The New School Health Handbook. Englewood Cliffs, NJ: Prentice Hall, 1989.

American Academy of Pediatrics: Committee on Practice and Ambulatory Medicine. "Recommendations for Preventive Pediatric Health Care." In AAP News, July 1991.

SAMPLE

SCHOOL HEALTH PROGRAM

BLOOD PRESSURE SCREENING REFERRAL

Dear Parent:

Blood pressure screening is one of the preventive health services provided by the School Health Program in this District. Your child's class was recently screened as part of a health awareness initiative.

It is recommended that a student check with his doctor for further examination when his blood pressure is elevated at three different times. Your child received the following readings:

Date of Screening	Blood Pressure Reading	Arm Used
1. ____________	____________________	Rt.____ Lt.____
2. ____________	____________________	Rt.____ Lt.____
3. ____________	____________________	Rt.____ Lt.____

Please have your child examined by your doctor and ask the doctor to complete the form below and return to your school nurse.

Nurse:______________________________ School:______________________________

Address:____________________________ Phone:_______________________________

Physician's Report of Blood Pressure Examination

Student's Name______________________________

Examination Findings:

Recommendations and/or treatment:

Do you wish to have this student's blood pressure monitored at school?

Yes____ No____ Frequency__________________

Physician's
Printed Name:_____________________________ Signature:______________________

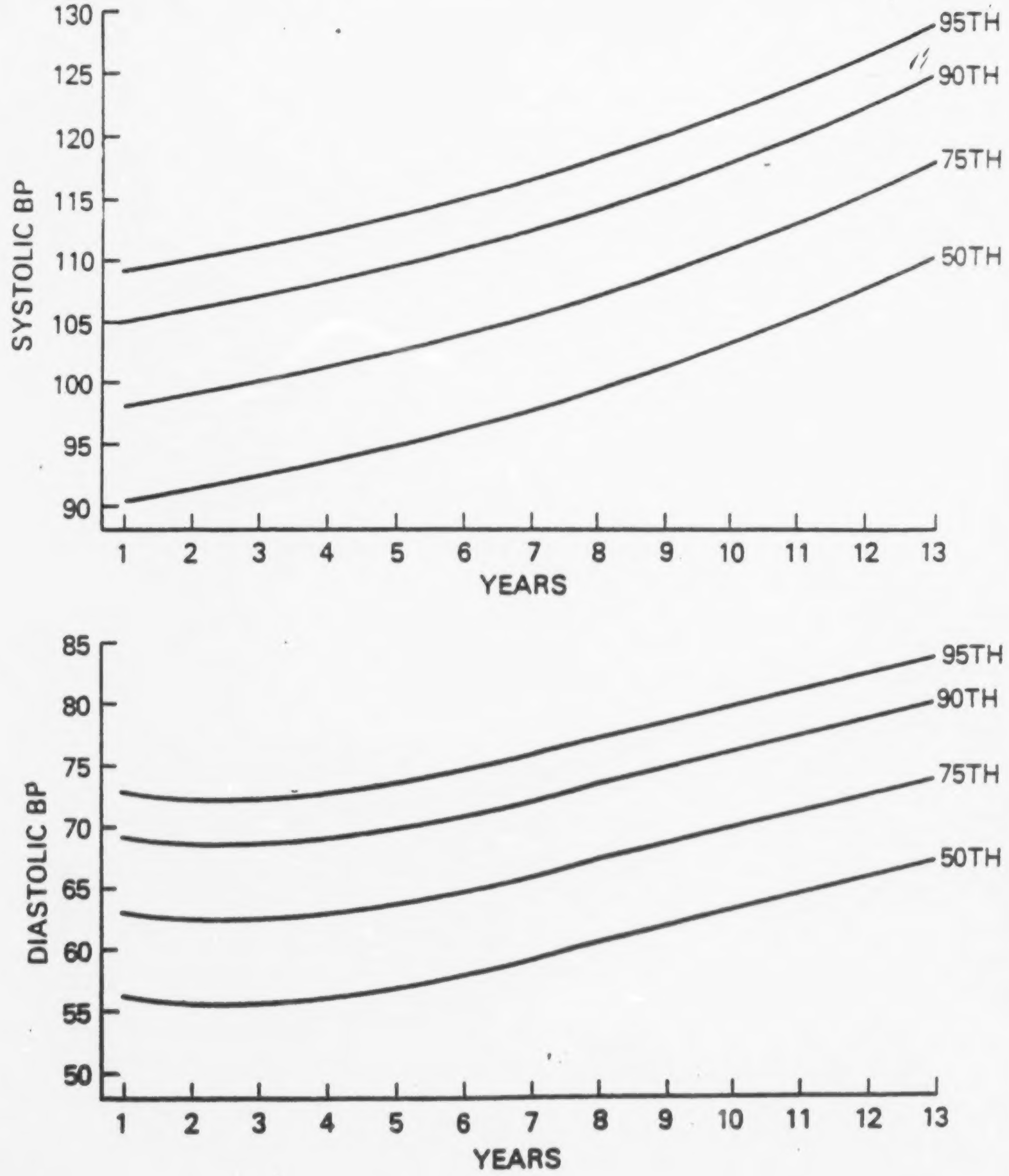
Office Phone:_____________________________ Date:___________________________

Please return to your child's school or to school nurse.

Source: School Health Program Manual South Carolina
Department of Health and Environmental Control, 1990

FIGURE 3

AGE-SPECIFIC PERCENTILES OF BLOOD PRESSURE MEASUREMENTS IN BOYS AGES 1 YEAR TO 13 YEARS



90TH PERCENTILE													
SYSTOLIC BP	105	106	107	108	109	111	112	114	115	117	119	121	124
DIASTOLIC BP	69	68	68	69	69	70	71	73	74	75	76	77	79
HEIGHT CM	80	91	100	108	115	122	129	135	141	147	153	159	165
WEIGHT KG	11	14	16	18	22	25	29	34	39	44	50	55	62
YEARS	1	2	3	4	5	6	7	8	9	10	11	12	13

Report of the Second Task Force on Blood Pressure Control in Children, 198'

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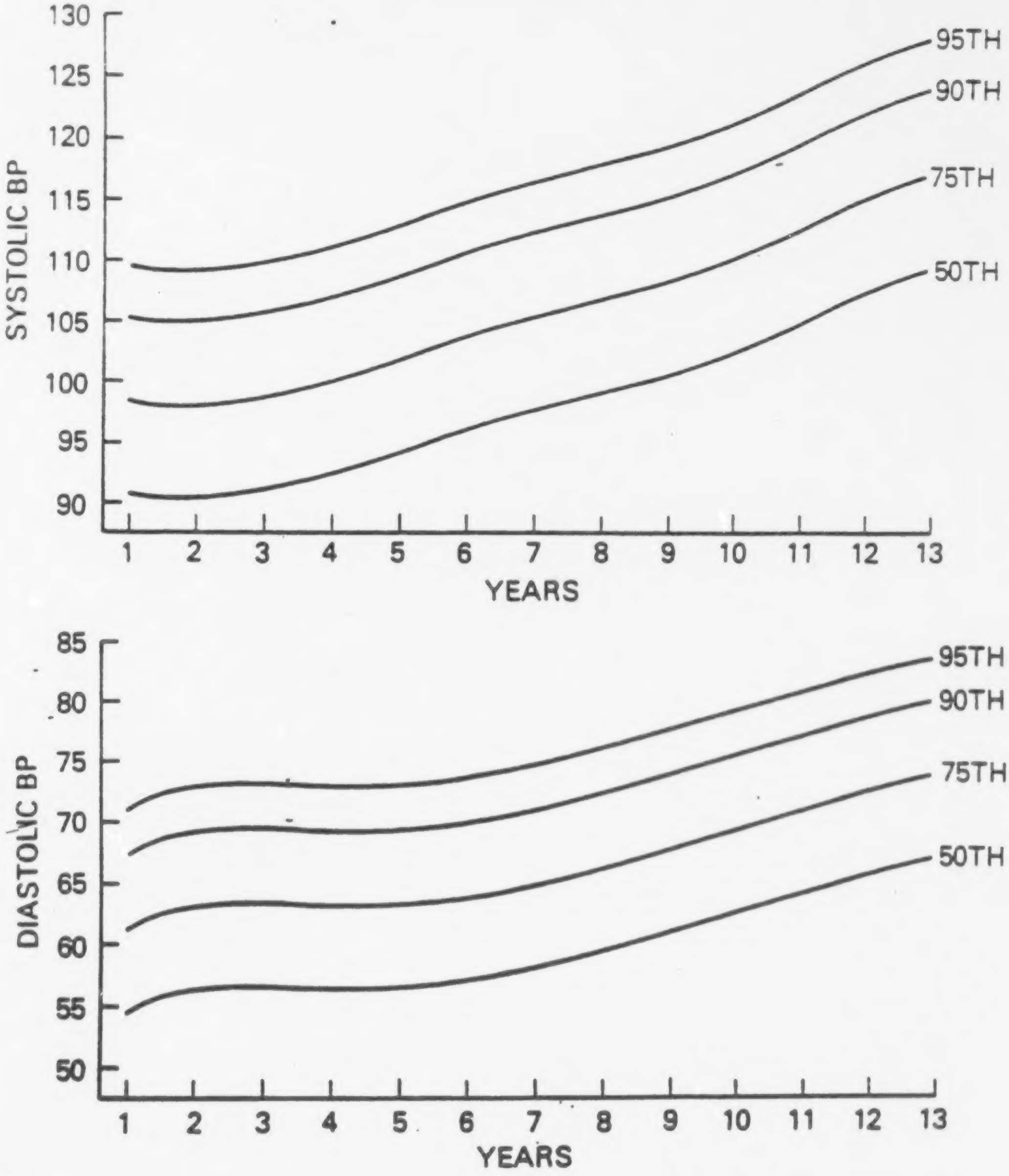
FIGURE 4

AGE-SPECIFIC PERCENTILES OF BLOOD PRESSURE MEASUREMENTS IN GIRLS AGES 1 YEAR TO 13 YEARS

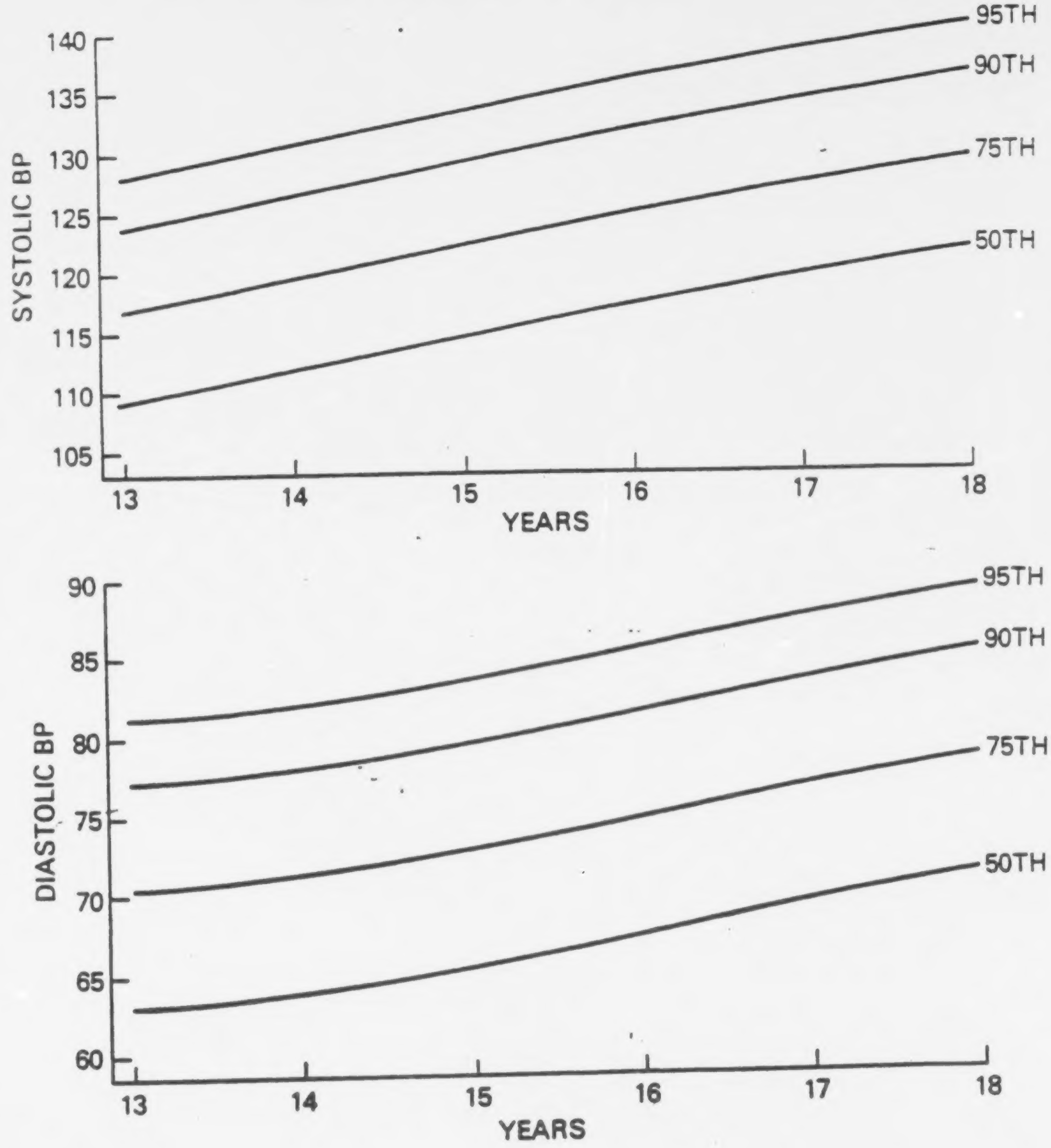


90TH PERCENTILE													
SYSTOLIC BP	105	105	106	107	109	111	112	114	115	117	119	122	124
DIASTOLIC BP	67	69	69	69	69	70	71	72	74	75	77	78	80
HEIGHT CM	77	89	98	107	115	122	129	135	142	148	154	160	165
WEIGHT KG	11	13	15	18	22	25	30	35	40	45	51	58	63
YEARS	1	2	3	4	5	6	7	8	9	10	11	12	13

Report of the Second Task Force on Blood Pressure Control in Children, 1987.

FIGURE 5

AGE-SPECIFIC PERCENTILES OF BLOOD PRESSURE MEASUREMENTS IN BOYS AGES 13 TO 18 YEARS

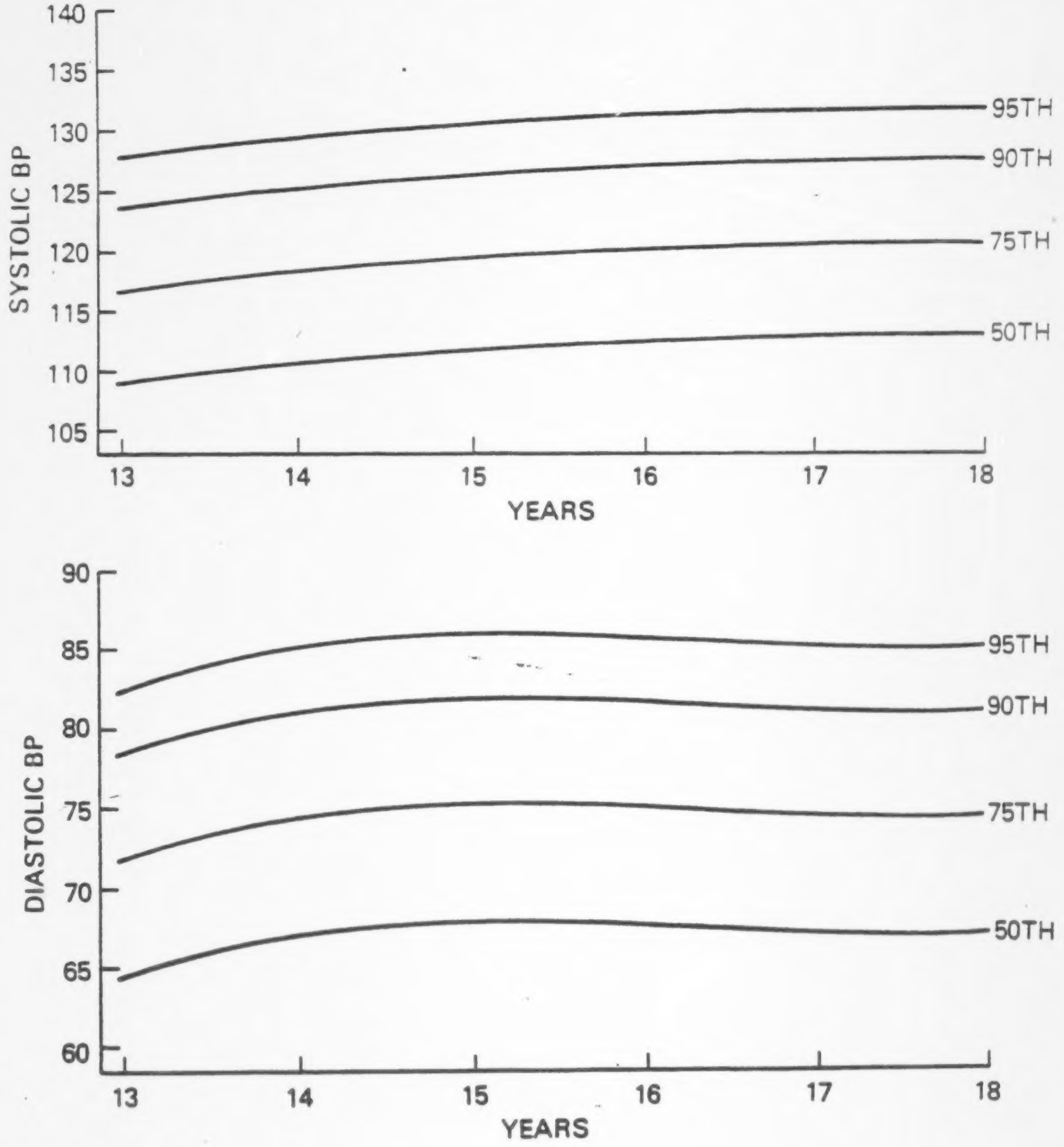


90TH PERCENTILE						
SYSTOLIC BP	124	126	129	131	134	136
DIASTOLIC BP	77	78	79	81	83	84
HEIGHT CM	166	172	178	182	184	184
WEIGHT KG	62	68	74	80	84	86
YEARS	13	14	15	16	17	18

Report of the Second Task Force on Blood Control in Children, 1987.

FIGURE 6

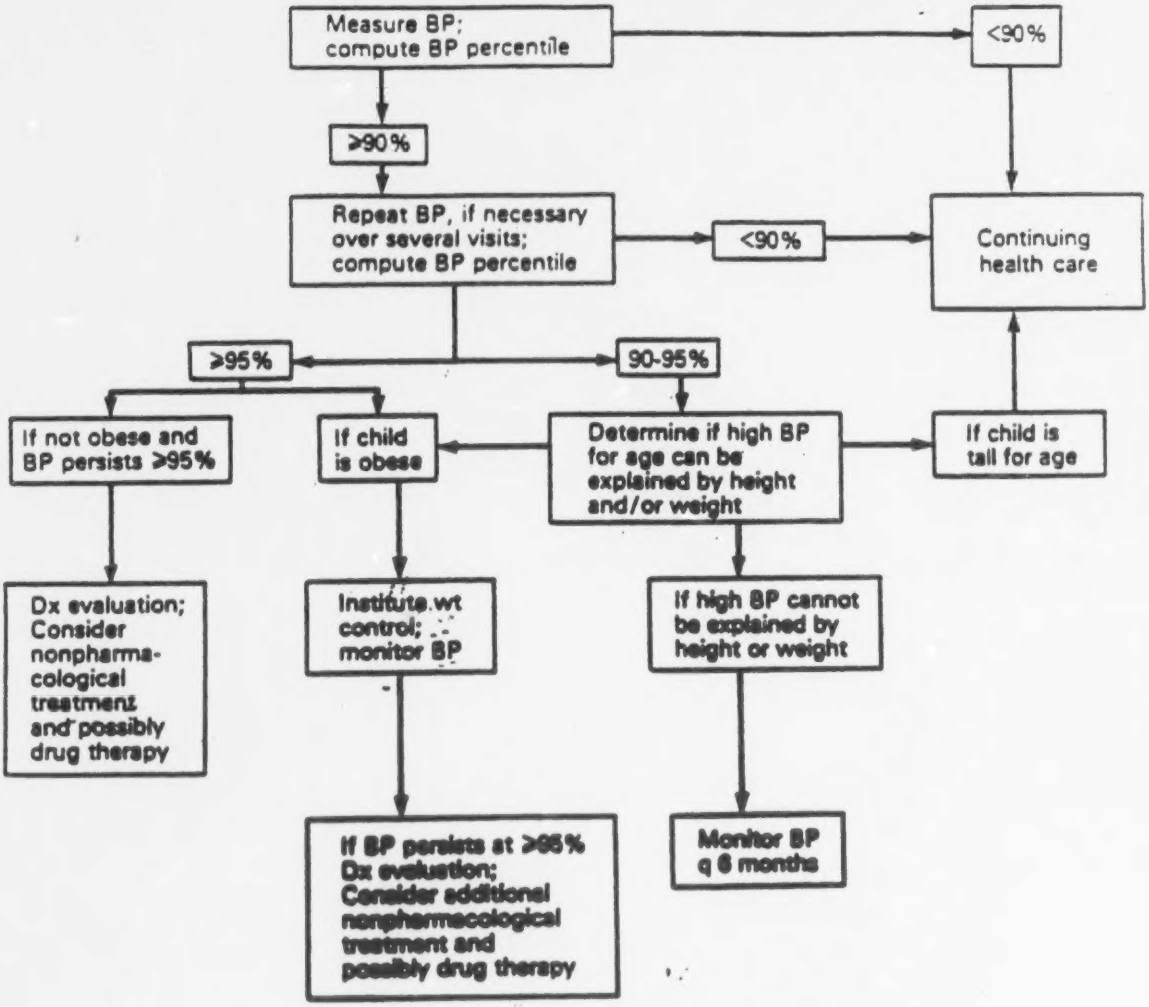
AGE-SPECIFIC PERCENTILES OF BLOOD PRESSURE MEASUREMENTS IN GIRLS AGES 13 TO 18 YEARS



90TH PERCENTILE						
SYSTOLIC BP	124	125	126	127	127	127
DIASTOLIC BP	78	81	82	81	80	80
HEIGHT CM	165	168	169	170	170	170
WEIGHT KG	63	67	70	72	73	74
YEARS	13	14	15	16	17	18

FIGURE 7

ALGORITHM FOR IDENTIFYING CHILDREN WITH HIGH BLOOD PRESSURE


Measure BP; compute BP percentile
<90%
≥90%
Repeat BP, if necessary over several visits; compute BP percentile
<90%
Continuing health care
≥95%
90-95%
If not obese and BP persists ≥95%
If child is obese
Determine if high BP for age can be explained by height and/or weight
If child is tall for age
Dx evaluation; Consider nonpharmacological treatment and possibly drug therapy
Institute wt control; monitor BP
If high BP cannot be explained by height or weight
If BP persists at ≥95% Dx evaluation; Consider additional nonpharmacological treatment and possibly drug therapy
Monitor BP q 6 months

HEIGHT AND WEIGHT SCREENING

Legal Basis

While there is not a specific mandate for height and weight screenings, height and weight measurements may be components of a required physical assessment. Please see Section III. of this document, Services: Health and Physical Assessment.

Recommendation

Screening Program

Students should be weighed and measured annually. Growth in height and weight is one of the most salient characteristics of normal children, and its absence should always be noted. Height and weight screening is the simplest, quickest, and one of the most important screenings for school children. It is an ideal task to assign to a school health paraprofessional.

Reference:

American Academy of Pediatrics. School Health: A Guide for Health Professionals. Elk Grove Village, Ill.: the Academy, 1987.

Newton, Jerry, M.D. The New School Health Handbook. Englewood Cliffs, N.J.: Prentice Hall, 1989.

Rationale

Purposes of height and weight screening are:

- To identify the student who is not growing and developing normally.
- To stimulate interest in self-responsibility for growth and development.
- To show the relationship between good health practices and growth.
- To create an awareness among school personnel and parents of the relationship of good nutrition to growth.

Procedures and Techniques

Based on local school division policies, screening may be done by classroom teachers, physical education teachers, or school nurses; however, all screeners should receive instruction in proper techniques to be used.

Weight:

- Be sure that scales are accurate; scales' balance should be checked yearly.
- Have the student remove shoes, coats, sweaters, and heavy objects in pockets.
- Record weight to the nearest pound or quarter pound.

Height:

- Ask student to stand with back against measuring tool.
- The student should remove shoes, stand with heels close together, legs straight, arms at sides, and shoulders relaxed. The student's knees should be straight, with heels on floor and with head, shoulder blades, buttocks and heels touching the wall.
- Lower headboard so that it rests against crown of student's head.
- Measure to nearest quarter inch.

Referral Criteria

Standard of reference is Department of Health and Human Services (formerly Department of Health, Education, and Welfare) Growth Charts (Federal MCH-220 forms). Please see Appendix D-1 and Appendix D-2 for a copy of the following Federal MCH-220 forms:

- Growth Charts with Reference Percentiles for Boys 2 to 18 Years of Age
- Growth Charts with Reference Percentiles for Girls 2 to 18 Years of Age

Graph stature (height) for age, weight for age, and weight for stature (height) - refer students meeting the following criteria to the school nurse for further assessment of family history, current medical evaluation, etc.:

- Stature for Age, Weight for Age, or Weight for Stature below the 5th percentile.
- Stature for Age, Weight for Age, or Weight for Stature above the 95th percentile.
- Percentile levels deviating 25 percentile points or more from the established pattern of growth.

If the school nurse is unavailable, school personnel conducting the screening should make a referral directly to the student's physician if any of the above events occur.

NUTRITION

Legal Basis

National School Lunch Act, 1946.

Child Nutrition Act, 1966.

Recommendation

Introduction

All children require food to grow and develop, but good nutrition goes beyond growth. It can have an impact on a child's ability to learn. Mild undernutrition is associated with an increased risk of illness, decreased activity level, decreased attention span, poor social interaction, decreased independence, and potential delays in motor and verbal skill development. Studies have shown a decline in performance on certain tests when well-nourished children skip breakfast. Nutrient deficiencies such as iron deficiency anemia may lead to irritability, fatigue, decreased attention span, and poor test scores.

Poverty is commonly related to poor nutritional status. With the increasing number of children raised in impoverished environments, all school employees should be concerned about the nutritional well-being of school-age children. Surveys show that approximately 20 percent of American children live in poverty and that a significant number of children in the U.S. suffer from hunger and/or undernutrition. In 1987 the U.S. Conference of Mayors reported an 18 percent national increase in the number of families with children seeking assistance from emergency food shelters.

Programs are available through schools to provide nourishing meals and nutrition education for children. All school personnel should play an active role in implementing and promoting these programs to meet the growth and developmental needs of students and to provide an optimal learning environment.

Nutrition Programs in Schools

National School Lunch and Breakfast Programs:

The National School Lunch and Breakfast programs are child Nutrition programs available to all school children regardless of income. These programs are administered at the federal level by the Food and Nutrition Service (FNS) of the United States Department of Agriculture (USDA); at the state level (for public schools) by the Department of Education; and at the local level by the school board. The programs provide meals for children, based on an established meal pattern. The meals are designed to provide one third of the recommended dietary allowance for children. Free and reduced-price meals are available, based on household income and size.

Nutrition Education and Training Program:

The Nutrition Education and Training (NET) program is administered by FNS of the USDA. It promotes nutrition education for school children through a grant to the states. Objectives of this program include the following:

- To encourage good eating habits.
- To provide nutrition education and/or food service training for food service personnel and educators.
- To promote the cafeteria as a learning environment for healthy nutrition.
- To provide funding for nutrition education materials.

Every school can take an active role in increasing accessibility to child nutrition programs and in promoting good nutrition for all students. Steps to be taken to achieve this goal include the following:

- Work with school administrators, school board members, food service personnel, parents and students to increase participation in nutrition programs.
- Incorporate nutrition education in the classroom and cafeteria.
- Ensure that nutritious choices are available if a school sells competitive foods.
- Incorporate nutrition goals and objectives in the individualized education plans for children with special health care needs.

Dietary Guidelines for Americans

The Dietary Guidelines for Americans is a publication developed by the U.S. Department of Agriculture and the U.S. Department of Health and Human Services. These guidelines offer general nutrition recommendations for all healthy Americans, ages two years and older. Guidelines pertaining to school-age children are as follows:

- Eat a variety of foods.
- Maintain healthy weight.
- Choose a diet low in fat, saturated fat, and cholesterol.
- Choose a diet with plenty of vegetables, fruit, and grain products.
- Use sugar only in moderation.
- Use salt and sodium only in moderation.

The purpose of these guidelines is to promote good health through healthy eating habits. These good habits should be taught and reinforced throughout the life cycle.

Nutrition Management of Children with Special Health Care Needs

Chronically ill and handicapped children are at risk for nutrition-related health problems. Frequent problems identified in this group of children include inadequate intake of calories and nutrients, delayed growth, underweight and overweight conditions, dental problems, and constipation.

Coordination between food service personnel, educators, and the child's family is essential to the development of a successful dietary and feeding program for a child with special needs. Regulations of the National School Lunch Act provide for food substitutes to accommodate medical or special dietary needs for students. Handicapped students requiring a special diet must have a written order from a physician that identifies the handicapping condition, states dietary changes, and gives substitutions for the child's lunch and/or breakfast. The chronically ill child who is not identified as a handicapped student must have a written order from a recognized medical authority (i.e., physician, nurse, registered dietitian, etc.) that includes a statement indicating that the child's diet is restricted by medical or other special needs, the foods that the child cannot eat, and foods that may be substituted in his or her diet.

Developing nutrition goals and objectives for a child with special dietary needs during the school day is an excellent way to assist a child in complying with his/her diet and learning about nutrition. The individualized education plan (IEP) provides an ideal tool for integrating nutrition education into the school curriculum.

Nutrition and Sports

Many athletes, coaches, and parents are eager to have the most current information on nutrition as it relates to athletic performance. Unfortunately, much misinformation exists regarding nutrition topics such as pre-event meals, diets for weight gain or weight loss, vitamin and mineral supplements, and optimal body composition. There are many hazards to sports nutrition myths and fad diets. A student may harm both his/her athletic performance and physical health without proper guidance and sound nutrition practices.

The calorie and nutrient needs for an athlete should be calculated on basal metabolism, physical activity level, and growth. As calories are utilized by a young athlete, priority is given to metabolism and activity. Therefore, growth may be impaired if the athlete's dietary intake level is inadequate.

An area of concern for many health professionals is the use of severe calorie and fluid restrictions for weight loss to enable the student to qualify for sports. Such restrictions may impair performance, deplete energy and fluid stores, interfere with temperature control mechanisms, and cause other health problems. In addition, high school athletes are susceptible to eating disorders such as anorexia nervosa and bulimia. These may result in severe physical and psychological problems. Overemphasis on weight is a contributing factor for the development of eating disorders.

Sports nutrition resources are identified below. They provide guidelines for safe weight loss and weight gain, recommended body fat percentages for specific sports and fluids needs for athletes, as well as information on sports nutrition myths. An additional resource is the NET program that sponsors a nutrition workshop for coaches each year.

Resources

Please see Section VIII. of this document, Virginia Forms for copies of the following:

- Nutrition Worksheet and Referral Form
- Nutrition Related Problems (Supplement for Nutrition Worksheet and Referral Form)

Please see Appendix D-1 and Appendix D-2 for copies of the following:

- Growth Charts with Reference Percentiles for Boys 2 to 18 Years of Age
- Growth Charts with Reference Percentiles for Girls 2 to 18 Years if Age

Consultation and training on nutrition for school-age children are available through the Virginia Department of Education and the Virginia Department of Health. Resources and references are listed below.

Agencies:

- Virginia Department of Education
  School Food Service/NET Program
  P.O. Box 6Q
  Richmond, VA 23216

- Virginia Department of Health
  Division of Public Health Nutrition
  P.O. Box 2448
  1500 East Main Street Station
  Room 130
  Richmond, VA 23218-2448

Materials:

- The Relationship between Nutrition and Learning: A School Employees Guide to Information and Action.
  NEA Human and Civil Rights
  1201 Sixteenth Street, NW
  Washington, DC 20036

- Dietary Guidelines for Americans
  MCH Clearinghouse
  38th and R. Streets, NW
  Washington, DC 20057

- Nutrition Management of Handicapped and Chronically Ill School Age Children
  Virginia Department of Education
  James Monroe Building
  P.O. Box 6 Q
  Richmond VA 23216
  Cost: $10.00

- Food Power: A Coaches Guide to Improving Performance
  Dairy and Food Nutrition Council of the Southeast, Inc.
  1601 Rolling Hills Dr.
  Surry Building, Suite 122
  Richmond, VA 23229-5011

- Body Culture: A Sports Nutrition Program for High School Athletes
  National Live Stock and Meat Board
  444 North Michigan Ave.
  Chicago, IL 60611

- Sports Nutrition Handout Series
  Nutrition Services, Sports Medicine Systems, Inc.
  830 Boylston St.
  Brooklyn, MA 02167
  (617) 739-2003

References

Parker, L. The Relationship between Nutrition and Learning: A School Employees Guide to Information and Action. Washington, D.C.: National Education Association of the United States, 1989.

American Journal of Clinical Nutrition. 34:1526, 1981.

Pediatrics. 71:887, 1983.

Forbes, G.B., ed. Pediatric Nutrition Handbook. (2nd Edition). Elk Grove Village, Ill.: American Academy of Pediatrics, 1985.

Clark, N. Nancy Clark's Sports Nutrition Guidebook. Champaign: Leisure Press, 1990.

Smith, N.J. and Worthington-Roberts, B. Food for Sport. Palo Alto: Bull Publishing Company, 1989.

National Institutes of Health Consensus Development Panel. "National Institutes of Health Consensus Development Statement: Define Diets and Childhood Hyperactivity." In The American Journal of Clinical Nutrition, 37:161-165, 1983.

Milich, R., Walraich, M., and Lindgren, S. "Sugar and Hyperactivity: A Critical Review of Empirical Findings." In Clinical Psychology Review, 6:493-513, 1986.

SCHOOL PROCEDURES FOR CHILD PROTECTIVE SERVICES

RECORDING AND REPORTING

Legal Basis

Code of Virginia Section 63.1-248.3. Physicians, nurses, teachers, etc., to report certain injuries to children.

Excerpt:

See Section VI. of this document, Code of Virginia: Child Abuse and Neglect.

Note:

This law does not say the professional must have proof or be convinced of abuse or neglect of a child; suspicion is all that is needed.

The law makes allowances for "chain of command" reporting. The school system or individual school can establish a policy that states that a person who suspects that a child is abused or neglected (usually a classroom teacher or school nurse) can report his or her suspicion to a designated person who in turn reports the matter to the local Department of Social Services. It is important that the chain of command be responsive to the need to immediately report suspected child abuse.

The law establishes a penalty for not reporting suspected abuse, and considers it a misdemeanor criminal offense.

This law additionally states that the reporter must make available to the local Department all information that is the basis for the suspicion. This can include confidential information about the child/family that is contained in school records.

Code of Virginia Section 63.1-248.5. Immunity of person making report, etc., from liability.

Excerpt:

See Section VI. of this document, Code of Virginia: Child Abuse and Neglect.

Note:

This law stipulates that a person who makes a report of suspected child abuse/neglect shall be immune from any civil or criminal liability in connection with the report, unless the report is proven to be made with malicious intent.

Code of Virginia Section 63.1-248.17. Cooperation by state entities.

Excerpt:

See Section VI. of this document, Code of Virginia: Child Abuse and Neglect.

Note:

This law states that all law enforcement departments and other state and local departments, agencies, authorities and institutions shall cooperate with each local Department of Social Services in the detection and prevention of child abuse.

Recommendation

Reporting

It is suggested that each school/school division develop a plan for reporting child abuse and identify the contact person(s) for the local Department of Social Services. If there are any questions about the interpretation of the information, please check with the local department. Your local Department will be interested in your questions and in your concerns.

Reports can be made to the local Department of Social Services during working hours or to the State Child Abuse Hotline in Richmond (1-800-552-7096). The hotline operates twenty-four hours a day every day of the year. Information received on the hotline is forwarded to the appropriate locality for investigation. Reports can be made anonymously. Documentation is completed according to local school division policy.

Use of reporting forms should be based on local policy. Please see end of this section for a suggested reporting form, Suspected Child Abuse/Neglect.

Tips:

Have the following information readily available:

- The child's full legal name and nicknames, date of birth, home address, and home telephone.
- The parent/guardian's name and work telephone number. If the legal guardian does not live with the child, the guardian's address is needed.
- Names and ages of siblings and what schools or grades they attend.
- As much information as possible about the incident involving the child - especially where, when, and who was present.

When describing an injury (cut, mark, bruise) be specific!

- Note the exact location on the body.
- Note the size of the mark - estimate in inches, or in relation to a common object (i.e., size of a quarter, size of an egg).
- Note the color of the injury. Injuries often change color with the passage of time. The colors can range from red to black to purple to green and yellow.

In general, relate exactly what the child said in his/her own words. Be careful not to interpret what the child said. If you question the child, use open-ended questions. Be careful not to plant ideas or interpretations of what happened in the child's mind.

Remain calm, no matter how upsetting the information. If you react with shock, anger, or disgust at what the child tells you, the child may interpret that he/she is at fault and has done something wrong, and may be unwilling to reveal further information.

Never make promises you can't keep, like "Your parents will not be angry". You can tell the child what to expect next -- that you will be talking with a person who will try to help him or her.

Next Steps:

Many times school personnel are unaware of what occurs after a report, and may not understand why what appears to be an "obvious" situation cannot be investigated.

Once the local Department of Social Services receives information, it will determine whether or not the information can be processed as a Child Protective Services Complaint for Investigation. Four criteria must be met: Is the child under 18 years of age?; Is there a caretaker relationship between the victim and alleged abuser/neglector? A caretaker is anyone (teenager, sibling, adult) who is responsible for that child. If you suspect abuse/neglect but are not sure if the person is a caretaker, call your local Department of Social Services. It will decide. Does the allegation fall into a definition of abuse/neglect?; and does that individual department have jurisdiction?

If the answer to all four questions is "yes" then the department is obligated to investigate. The law gives the department forty-five days to complete an investigation. There is no standard at this time that states how soon an investigation must start. Generally, that is a function of how severe the risk to the child appears to be from the information presented. If the department does not have the legal authority to investigate the allegations, the incident/situation may be handled differently. If the person responsible for the suspected abuse was not a "caretaker" (and the Department of Social Services could not intervene), the suspected incident should be referred directly to the parents, police, or another agency. Your local Department of Social Services will be able to help identify other options.

Investigation

Once the department has accepted a report, it will be investigated.

Typically, the social worker who is investigating the allegations tries to interview a child in a neutral setting such as school.

The law gives the Child Protective Services social worker the authority to interview the child and any siblings without the prior consent of the parent/guardian. The child and siblings may be interviewed without the presence of the parent, guardian, school personnel or any other individual standing in loco parentis. (Code of Virginia Section 63.1-248.10).

The worker may take photographs of the child without the consent of the parent/guardian. (Code of Virginia Section 63.1-248.13).

The investigative worker will also talk with the alleged abuser/neglector, the parents/guardians (if different) and any other individuals who may have information about the child's care relating to the allegations - such as a doctor, teacher, neighbors.

The decision as to whether or not child abuse or neglect occurred must be made within forty-five days after a report is received. the decision is based on the information gathered during the investigation. There are three possible findings:

- "Founded" - Abuse/neglect has occurred;
- "Unfounded" - No evidence that abuse/neglect has occurred; and,
- "Reason to Suspect" that abuse/neglect has occurred.

Just because a situation is labeled "unfounded" or "reason to suspect" does not mean that the family may not be having problems. Such a decision only says that according to the Department of Social Services policy the incident cannot be labeled as abusive/ neglectful. Often times, the social worker will recommend changes or services to the family.

The Child Protective Services Investigation and any subsequent services provided to the child and the family are confidential. If you were not an anonymous reporter, the department may notify you very briefly of the investigative outcomes. The only time more detailed information is released is when the family gives express written consent.

The school may be instrumental in providing assistance to the family to prevent the abuse or neglect of children. Such prevention programs may be in the form of support groups and educational programs as well as students utilizing the many programs developed for awareness and education of family problems and solutions.

Definitions of the Types of Abuse/Neglect

Physical Abuse:

Severe injury or threat of severe injury to a child by a caretaker.

Physical Neglect:

Caretakers do not provide essentials such as food, clothing, shelter, or appropriate supervision. Check with your local Department of Social Services about what constitutes "appropriate supervision".

Medical Neglect:

Failure of caretaker to follow through regimen of care; can be physical, psychological, or dental.

Mental Abuse:

Caretaker's actions cause documentable injury to a child's mental functioning.

Mental Neglect:

Caretaker's inactions cause documentable injury to a child (ex. "Failure to thrive" child).

Bizarre Discipline:

Caretaker uses markedly unusual, eccentric, irrational or grossly inappropriate procedures to modify a child's behavior. Focus is on the caretaker's actions not just the injury to the child.

Sexual Abuse:

Caretaker's actions are consistent with the descriptions in the Criminal Code of Virginia (intercourse, oral-genital contact, exposure) or actions that are exploitative or harassing.

Reference

Prepared by: Lynn A.K. Berry, Social Worker Supervisor, City of Manassas, Department of Social Services, Va.

SAMPLE

SCHOOL HEALTH PROGRAM
SUSPECTED CHILD ABUSE/NEGLECT

TO: CHILD PROTECTIVE SERVICES, DSS

Student's Name　　Date of Birth　　Sex

Address

Name of Parents or Guardians

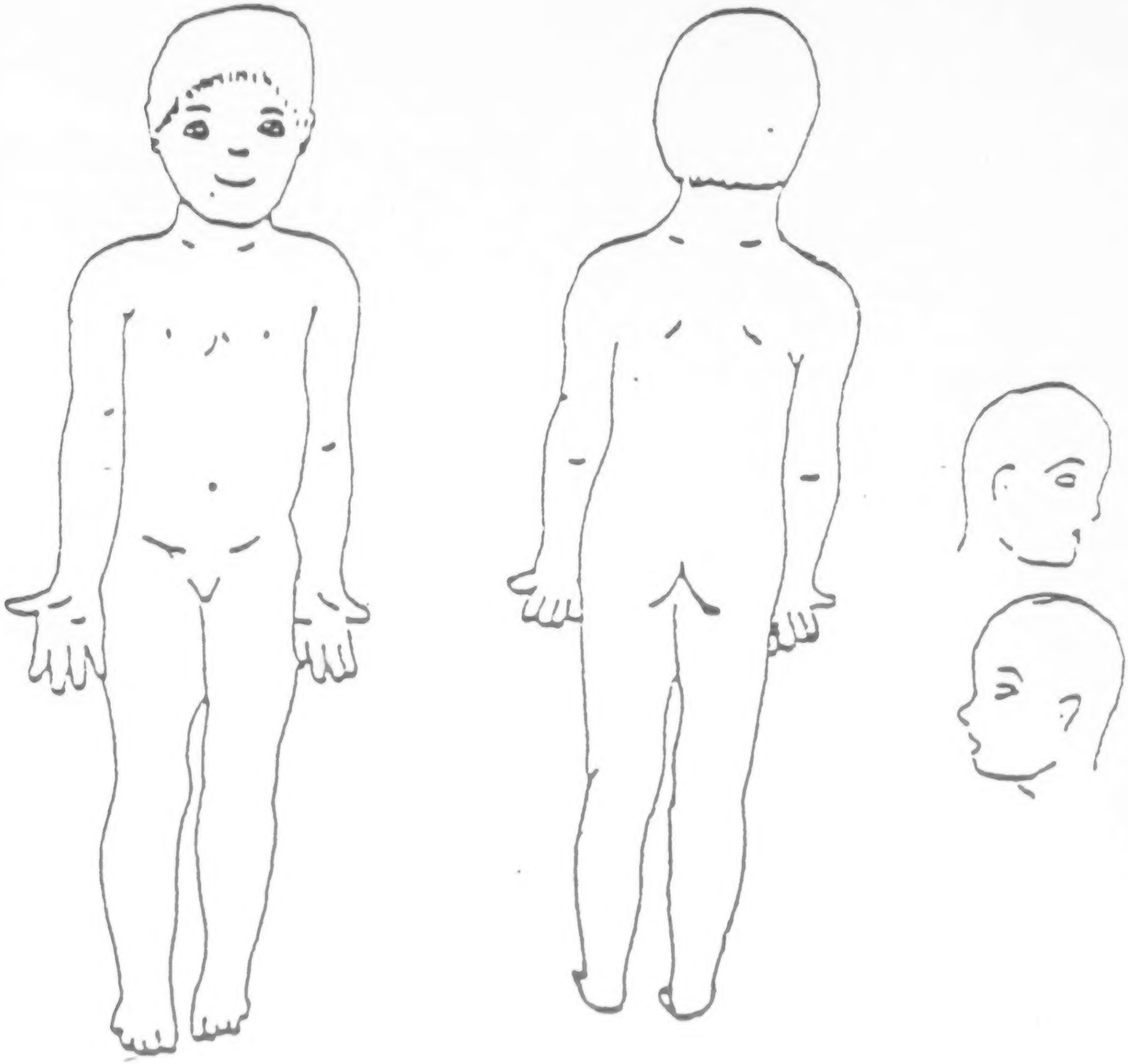
School　　Grade

Check type of abuse being reported:
( )Physical Abuse　( )Neglect　( )Sexual Abuse　( )Emotional - Often Verbal
Description of Abuse (Use reverse side to illustrate)

Signature and Title of Person Making Report　　Date

To Whom Reported　　Date of Oral Report

Source: Adapted from School Health Program Manual. South Carolina Department of Health and Environmental Control, 1990.



Symbols:
A - Abrasion
Bl - Blister
Bu - Burn
Br - Bruise
La - Laceration
Le - Lesions
S - Scar
R - Rash
V - Vermin
O - Other (describe)

Severity:
Mild - (1)
Moderate - (2)
Severe - (3)

INDICATORS OF CHILD ABUSE AND NEGLECT

Legal Basis

Code of Virginia Section 63.1-248.3. Physicians, nurses, teachers, etc., to report certain injuries to children.

Excerpt:

See Section VI. of this document, Code of Virginia: Child Abuse and Neglect.

Recommendation

The following indicators are not diagnostic of child abuse or neglect, nor are they the only possible indicators. They are included as a guide for overall assessment of a suspected case.

Physical Abuse

Appearance:

- Unexplained bruises:

  Bruises on the face, lips, or mouth; bruises in various healing stages; bruises on large areas of torso, back, buttocks, or thighs; bruises that are clustered, forming regular patterns such as might be made by the use of a belt or cord.

- Unexplained burns:

  Burns by cigarettes, especially on feet, hands, back, buttocks or thighs; burns by immersion in hot liquid, including glove-or sock-like burns or doughnut-shaped burns on back and buttocks; burns in shapes resembling household objects such as an iron or burner; or burns by ropes tied on arms, neck, legs, or torso.

- Unexplained fractures:

  Fractures in various stages of healing or fractures which are multiple.

- Lacerations and abrasions:

  Wounds produced by the tearing of body tissue (laceration) or caused by rubbing or scraping the skin or mucous membrane (abrasion) that are located on the mouth, gums, lips, and/or eyes; or on the external genitalia.

- Human bite marks, especially when they appear to have been made by an adult.

Behavior demonstrating extremes which may be outside the range expected for the child's age group:

- Wariness of physical contact with adults
- Apprehension when another child cries
- Fear of his/her parent(s)
- States fear of going home or cries when it is time to go
- Child reports injury inflicted by a parent
- Statement made by child that offers contradictory information about how injury occurred

Mental Abuse/Neglect

- Habit disorders, such as biting, sucking, rocking, enuresis, over-or under-eating without physical cause
- Conduct disorders, including withdrawal and antisocial behavior, such as destructiveness, cruelty, and stealing
- Neurotic traits, such as sleep disorders, speech disorders, and inhibition of play
- Psychoneurotic traits
- Overly compliant, passive, and undemanding
- Extremely aggressive, demanding, or angry
- Over-adaptive behaviors which are either inappropriately adult or infantile

- Delays in physical, emotional, and intellectual development
- Attempts at suicide
- Frequent comments and behavior suggesting low self-esteem

Sexual Abuse

Children are usually quite open when describing illnesses and pains, but rarely will a child approach a nurse and state that he/she is a victim of sexual abuse. The more usual situation is that the child's behavior signals something is wrong. Therefore, the nurse needs to be attuned to signs that may indicate sexual abuse. The list of physical and behavioral signs that follows is not exhaustive. It is not necessary for all, or even a majority, of the signs to be present in a child to warrant concern. The nurse must believe that sexual abuse could be occurring and investigate further.

The child's age is also a factor to consider in assessing of possible sexual abuse. Toddlers and pre-school age children have difficulty verbalizing their fears and concerns. They may react to sexual abuse with insomnia, night terrors, or developmental regression. Compulsive masturbation and advanced sexual utterances may signify the child is being abused. Physical signs in children at this age may range from a stomach ache to dysuria. Particular attention must be given to any genital irritation, laceration, abrasion, bleeding, discharge, or infection. Venereal disease should be considered in children with anal or genital infection, discharge, or irritation.

Signals of Sexual Abuse:

- Unexpected sexual utterance or behavior, especially in young children, e.g., a child asking to see the school bus driver's sexual parts
- Unwilling to participate in physical activities
- Limited or no involvement in after-school activities
- Child may appear withdrawn, engage in fantasy or infantile behavior, or even appear retarded
- Poor peer relationship

- Vague resistance of being alone with an adult/parent figure
- Fear of going home
- Runaway behavior
- Moderate to severe anxiety or depression, especially in young children
- Unusual accumulation of money, candy, favors
- Vague reports of molestation by strangers
- Vague concern about or compulsive interest in own sexual parts by child
- Responds to sexual behavior with extreme aversion or with seduction and promiscuity
- Adolescent prostitution
- Nightmares
- Lighting fires, behavior associated with young male victims
- Real or imagined somatic complaints
- Pregnancy and/or venereal disease, particularly when child refuses to identify partner or has no known identified partner
- Unexplained vaginal discharge
- Bruises and/or bleeding of external genital, vaginal or anal areas, and inner thighs
- Pain or burning associated with urination or defecation
- Torn, stained, or bloody clothing
- Gagging response, sore throat, mouth or throat lesions (as the result of oral-genital contact)
- Difficulty in sitting or walking
- Signs of physical abuse

- Sudden weight gain or weight loss
- Chemical abuse

Further Indicators to the Potential for Sexual Abuse:

- The child was previously abused
- Any of the child's siblings were previously abused
- Pattern of rigid, restrictive control by the father of the social life of his female children
- Limited contacts with the outside world by the family as a whole and by its individual members
- Alcoholism in one or both parents
- Vague reports by parent(s) that their child has been sexually abused by a stranger
- Parents expect adult behavior from children and deal with them as though they were adults
- Role reversal in the family, with children "caring" for the parents rather than the reverse

Neglect

Signals of Neglect:

- Consistent hunger, poor hygiene, or inappropriate dress
- Consistent lack of supervision - refer to local guidelines
- Consistent fatigue or listlessness
- Abandonment
- Unattended medical needs

  Lack of diagnosis; lack of treatment/medications.

- Unusual behavior:

  Begging for or stealing food; constantly falling asleep in school; poor attendance in school; arriving at school very early or leaving very late; addiction to alcohol and/or drugs; engaging in delinquent acts; and rooming away from home without appropriate supervision.

References

School Health Program Manual. South Carolina Department of Health and Environmental Control, 1990.

The Educator's Role in the Prevention and Treatment of Child Abuse and Neglect, VSH & HS; DHHS Pub. #(OHDS) 84-30172, 1984.

UNIVERSAL PRECAUTIONS FOR HANDLING BLOOD/BODY FLUIDS IN SCHOOL

Legal Basis

Please refer to the Occupational Safety and Health Administration (OSHA) Final Bloodborne Pathogens Standard for most recent requirements.

Recommendation

Introduction

The following guidelines are designed to protect persons who may be exposed to blood or body-fluids of students or employees in a public school.

Anticipating potential contact with infectious materials in routine and emergency situations is the single most important step in preventing exposure to and transmission of infections. Preparation should be made to use appropriate precautions and techniques in all situations that may present the hazard of infection. Diligent and proper washing of hands, the use of barriers (i.e., latex gloves), appropriate disposal of waste products and needles, and proper care of spills are essential techniques of infection control.

Universal Precautions:

According to the concept of universal precautions, all human blood and certain human body fluids are treated as if known to be infectious for human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other bloodborne pathogens. This approach, previously recommended by Centers for Disease Control (CDC), and referred to as "universal blood and body-fluid precautions" or "universal precautions," shall be used in the care of all persons to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluid shall be considered potentially infectious materials. (Adapted from Policy for Infection Control in Health Department Personnel. Virginia Department of Health, March 1992.)

Latex Gloves for Viral Protection:

Investigators from the Johns Hopkins University School of Nursing have found that latex gloves are up to nine times more protective than vinyl gloves against leaks of viruses such as the HIV-1 virus which causes AIDS. (Reported in Nurses Environmental Health Watch, Volume XI, Number 1.) Therefore, the subsection, "Ways to Avoid Contact with Body Fluids" (follows "Hand Washing") gives differentiated uses of latex and vinyl gloves.

Hand Washing

Proper hand washing is crucial to preventing infection.

Procedure:

- Hands should be washed vigorously with soap under a stream of running water for approximately 10 seconds.
- Jewelry should be removed and stored in a safe place prior to initial handwashing (replace jewelry after the final hand washing).
- Rinse hands well with running water and thoroughly dry with paper towels. If soap and water are unavailable, wet towelettes, "handi-wipes," or instant hand cleaner may be used.

Hands should be washed before physical contact with student and/or body-fluids and after contact has been made.

Hands should be washed after contact with any used equipment (stethoscope, emesis basin, gloves, etc.)

If hands (or other areas of the skin) become soiled with blood or body-fluids, they should be washed immediately.

Hands should be washed after physical contact with each student whether or not gloves are worn. If gloves have been worn, remove and then wash hands.

Please see Figure 8, Eight Steps to Proper Hand Washing, at the end of this section.

Ways to Avoid Contact With Body Fluids

When possible, direct skin contact with body-fluids should be avoided. Disposable latex and vinyl gloves should be available in the school clinics. The use of gloves is intended to reduce the risk of contact with blood and body-fluids for the care giver as well as to control the spread of infectious agents from student/employee to student/employee.

Gloves should be worn when direct care may involve contact with any type of body-fluids. After they are used, gloves should be placed in a plastic bag or lined trash can, secured, and disposed of daily.

Latex gloves should be worn when changing dressings or sanitary napkins.

Latex gloves should be worn if the caregiver has broken skin on the hands or around the fingernails.

Latex gloves should be worn when cleaning up blood (e.g., nosebleeds), body-fluids and wastes where blood is present, and supplies that are soiled with blood.

Vinyl or latex gloves may be worn when changing a diaper or catheterizing a student where blood is not visible. Latex gloves should be worn if blood is visible.

Vinyl or Latex gloves should be worn when providing mouth, nose or tracheal care, unless blood is present. Wear latex gloves if visible blood is present.

If spattering of body-fluids is anticipated, the clothing of the caregiver should be protected with apron or gown. The apron or gown should be laundered or disposed of after it is used and should not be used again until it is clean.

If cardiopulmonary resuscitation is needed, a disposable face shield should be used.

Disposal of Infectious Waste

All used or contaminated supplies (including gloves and other barriers), except for syringes, needles, and other sharp implements, should be placed in a plastic bag which is then sealed. This bag should be placed in a second plastic bag which must also be sealed. The double-bagged waste can then be thrown in the garbage, out of reach of children or animals.

Agreements should be made with a local medical facility or the local health department to provide for the proper disposal of used needles, syringes, and autolets. Needles, syringes, and other sharp objects should be placed in a metal or other puncture-proof container immediately after use. To reduce the risk of a cut or an accidental puncture by a needle, NEEDLES SHOULD NOT BE RECAPPED, BENT, OR REMOVED FROM THE SYRINGE BEFORE DISPOSAL. Once it is full, the container should be sealed, double bagged, and kept out of the reach of children until it can be disposed of properly.

Body waste such as urine and vomitus should be covered with an absorbent sanitary material, then swept up and discarded in plastic bags. Feces should be disposed of in the toilet.

Clean-Up

Spills of blood and body-fluids should be cleaned up immediately with an approved disinfectant cleaner.

Wear gloves (see "Ways to Avoid Contact with Body Fluids.")

Mop up the spill with absorbent material.

Using the disinfectant cleaner supplied in the clinics or a one-part household bleach (sodium hypochlorite) in ten parts of water is another disinfectant that can be used. The area needs to be washed well.

Dispose of gloves, soiled towels, and other waste in sealed plastic bags in the garbage, as already indicated.

Routine environmental clean-up facilities (such as the clinic and the bathrooms) do not require modification unless contamination with blood or body-fluids should occur. If so, the area should be decontaminated, using the procedure outlined. Regular cleaning of noncontaminated surfaces such as toilet seats and table tops can be done with the standard cleaning solutions already used or the bleach solution mentioned above. Regular cleaning and removal of obvious soil is more effective than extraordinary attempts to disinfect or sterilize surfaces.

Rooms and dustpans must be rinsed in the disinfectant. Mops must be soaked in disinfectant, washed, and rinsed thoroughly. The disinfectant solution should be disposed of promptly down the drain.

Following clean-up, dispose of gloves and wash hands thoroughly.

Laundry

Whenever possible, disposable barriers (i.e., disposable gloves and gowns) should be used if contamination with blood or body-fluids is possible. If sheets, towels, or clothing become soiled, they should not be handled more than necessary. Wash with hot water and detergent for at least 25 minutes. Cool water washing is also acceptable if an appropriate detergent is used for the wash cycle. If the material is bleachable, add 1/2 cup of household bleach to the wash cycle. If material is not colorfast, add 1/2 cup nonclorox bleach (e.g., Clorox II, Borateem) to the wash cycle.

The most important factor in laundering clothing contaminated in the school setting is elimination of potentially infectious agents by soap and water. Addition of bleach will further reduce the number of potentially infectious agents.

Student clothing should be rinsed using gloves, placed in double plastic bag, and sent home for washing with appropriate instructions to parents.

Accidental Exposure

Accidental exposure to blood, body-products, or body-fluids places the exposed individual at risk of infection. This risk varies depending on the type of body fluid (blood vs. respiratory vs. feces), the type of infection (Salmonellae vs. Haemophilus Influenzae Virus vs. HIV) and the integrity of the skin that is contaminated.

Always wash the contaminated area immediately with soap and water.

- If mucous membrane splash (eye or mouth) or contamination of broken skin occurs, irrigate or wash the area thoroughly.
- If a cut or needle injury occurs, wash the skin thoroughly with soap and water.

In those instances where broken skin, mucous membrane, or a needle puncture occurs, the caregiver should document the incident. The student's parent or guardian should also be notified. The person who was exposed to infection should contact his or her physician for further care as outlined in recommendations by the Centers for Disease Control (CDC).

Pregnant Women

Pregnant women are at no higher risk of infection than other caregivers, as long as appropriate precautions are observed. However, due to the possibility of in utero transmission of viral infections such as cytomegalovirus (CMV) or HIV, as well as the potential for adverse outcomes with these congenitally-acquired infections, pregnant women should strictly adhere to universal precautions.

References

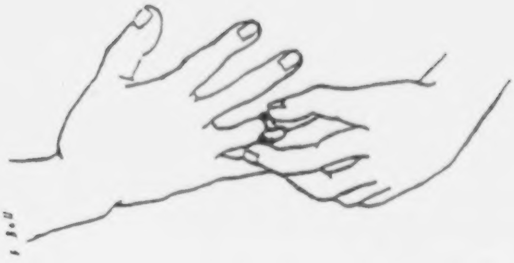
Virginia Department of Health. Policy for Infection Control in Health Department Personnel. March 1992.

Hanover County Public Schools. Universal Precautions for Handling Blood/Body Fluids in School.

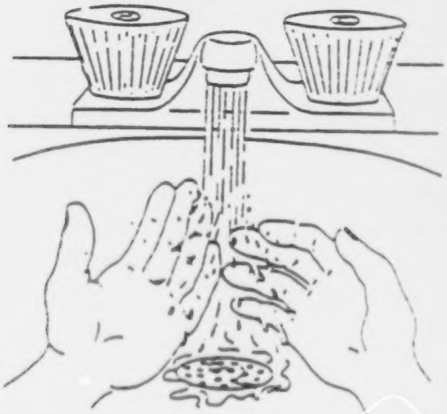
PATHFINDER and The School Nurse Organization of Minnesota. Managing the School Age Child With a Chronic Health Condition. Wayzata, Minn.: DCI Publishing, 1988.

Figure 8. Eight Steps to Proper Hand Washing

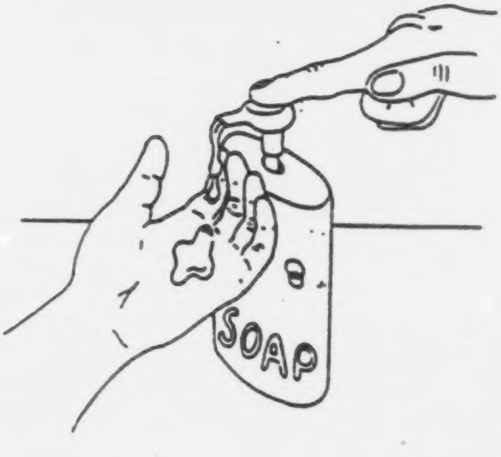
1. Remove Jewelry



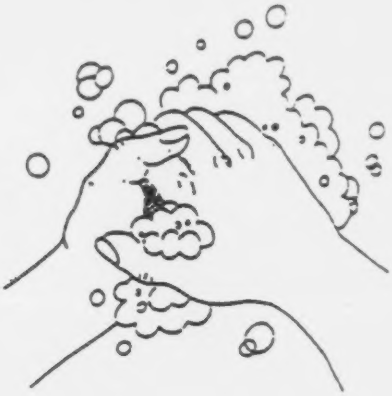
2. Wet hands with warm water



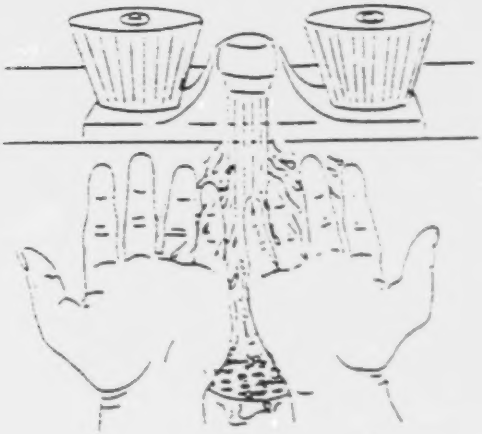
3. Apply liquid soap



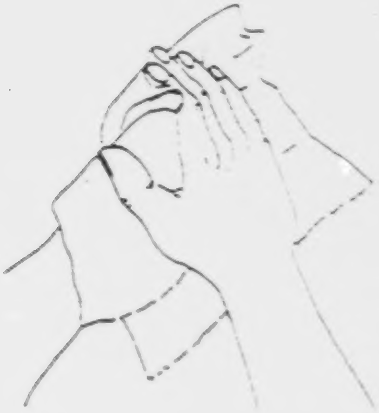
4. Wash hands



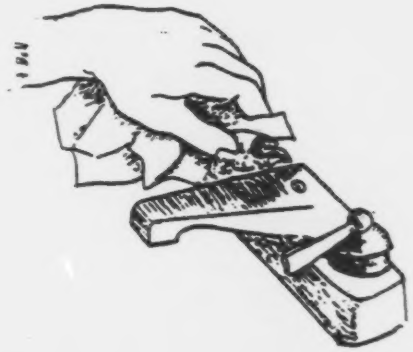
5. Rinse with running water



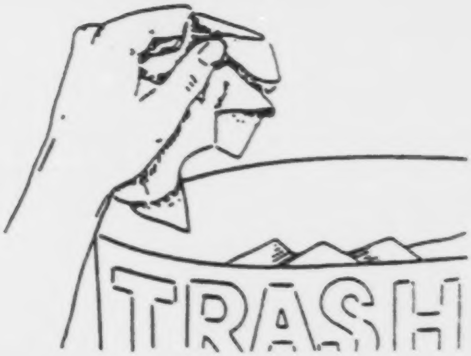
6. Dry hands with paper towel



7. Use paper towel to turn off water



8. Discard paper towel into trash



Source: A Comperative Effort of PATHFINDER and The School Nurse Organization of Minnesota. Managing the School Age Child With A Chronic Condition. Wayzata,MN: DCI Publishing, 1988.
Procedure Guidelines For Health Care of Special Needs Students in the Sch Setting. Colorado Department of Education and Colorado Department of Health, 1988.

CONTROL AND MANAGEMENT OF COMMUNICABLE DISEASE

Legal Basis

Code of Virginia Section 22.1-272. Contagious and infectious diseases.

Excerpt:

See Section VI. of this document, Code of Virginia: Contagious Diseases.

Recommendation

The responsibility for communicable disease control within the school is shared by school health program personnel and local health department personnel. The school setting, where children are in close contact with each other, enhances the transmission of many communicable diseases. School personnel can assist in controlling the spread of communicable disease by being alert to early signs and symptoms of disease.

Exclusion from School

A communicable disease may require exclusion from school. Isolation, however, is of limited value, since many communicable diseases, are most contagious during the prodromal phase (early signs of disease), before the disease is recognized and diagnosed. In many cases, the period of disability is longer than the period of communicability. Students with pediculosis, scabies, impetigo, conjunctivitis, and ringworm should be excluded from school until treatment has been initiated.

Parents should be taught to observe early signs of disease and should be encouraged to keep sick children at home. A communicable disease may be suspected when a combination of two or more of the following symptoms is present: headache, watery and inflamed eyes and nose, cough, elevated temperature, skin eruptions, sore throat, vomiting, and diarrhea.

- The sick child should be separated from other students in the place designated for this purpose.
- The parent or guardian should be notified and arrangements should be made for the child to be sent home as soon as possible.

- The child should be kept as comfortable as possible.
- The child should be observed closely to identify changes in his or her condition.

Control Procedures

Control procedures vary with each communicable disease. School officials should consult with the local health department for control measures for specific diseases.

Resources:

The following is a quick and easy reference to common communicable diseases among school children:

- Virginia Department of Health. Communicable Disease Reference Chart for School Personnel. February 1992. (See Appendix E for a reduced copy of chart.)

Also, the following publication gives in-depth information on various diseases and should be an available resource for school health personnel:

- The American Public Health Association. Control of Communicable Diseases in Man. Washington D.C.: the Association, 1990.

Enforcement:

Enforcement of state immunization and physical examination requirements also contributes to communicable disease control. Please see Section III. Immunization Requirements and Section III. Health and Physical Assessment.

Physicians, hospitals, and laboratories are required by state law to report certain communicable diseases to the local health department. School officials should also immediately notify by telephone the local health department in suspected cases of measles (Rubeola and Rubella), meningitis, tuberculosis, and hepatitis so that the necessary verification, follow-up, and control measures can be implemented. Only in the event of an emergency and with the authorization of the local health department, would schools be closed due to an outbreak of a communicable disease.

Children who are immuno-suppressed are more susceptible to infection than other children. Parents of these children should be notified during outbreaks of usual childhood diseases, such as chicken pox or influenza, and these students may remain at home.

Sexually transmitted diseases are also communicable, and the school should provide comprehensive and age-appropriate instruction on the principal modes of transmission and the best methods for reducing and preventing such diseases. Confidential counseling and referral information should be available to students.

Prevention

Prevention is a key component of communicable disease management. Health education and health counseling for students, staff, and parents should be part of the school health program. Stressing the importance of good health habits, especially hand washing, is essential among students and all school personnel. Health policies, including universal precautions, should be adhered to by all school personnel.

Please see Section III. of this document, Special Health Services: Universal Precautions.

References

American Academy of Pediatrics. School Health: A Guide for Health Professionals. Elk Grove, Ill.: the Academy, 1987.

American Academy of Pediatrics. Report of the Committee on Infectious Diseases. 1988.

American Public Health Association. Control of Communicable Diseases in Man. Washington D.C.: the Association, 1990.

Virginia Department of Health. Communicable Disease Reference Chart for School Personnel. February 1992.

Redican, Kerry; Olsen, Larry; and Boffi, Charles. Organization of School Health Programs. N.Y.: Macmillian Publishing Co., 1986.

Newton, Jerry, M.D. The New School Health Handbook. N.J.: Prentice-Hall, 1989.

Lewis & Thompson. Manual of School Health. Menlo Park, Cal.: Addison Wesley Publishing Co., 1986.

MANAGEMENT OF STUDENT, STAFF, AND VISITOR EMERGENCIES

Legal Basis

Code of Virginia Section 54.1-2969. Authority to consent to surgical and medical treatment of certain minors.

Excerpt:

Please see Section VI. of this document, Code of Virginia: Health Care for Minors/Emergency Care.

Code of Virginia Section 8.01-225. Persons rendering emergency care, obstetrical services exempt from liability.

Excerpt:

See Section VI. of this document, Code of Virginia: Health Care for Minors/Emergency Care.

Standards for Accrediting Public Schools in Virginia, Board of Education, amended May 27, 1988.

Excerpt:

"Each school shall have at least two full-time staff members who have attended and successfully completed courses approved by the State Board of Health in all of the following: cardiopulmonary resuscitation (CPR), Heimlich maneuver, and basic first aid."

Recommendation

Best Practice

Annual cardiopulmonary resuscitation (CPR) training and recertification of at least two full-time staff members is recommended. Since CPR is rarely administered, annual training and recertification to maintain skill level is recommended as best practice. CPR annual training and recertification is also necessary because there may be modifications to improve the technique of administering CPR from year-to-year. Modifications in the latest standards for CPR administration are taught at annual CPR recertification classes.

Rationale

- Illnesses and accidental injuries are common occurrences in children attending school.
- Students with chronic health problems or handicapping conditions often are at greater risk for injury, illness or extreme medical emergencies.
- Timely and appropriate administration of first aid can save lives and can minimize disability.
- Accidents should be carefully documented to preclude misinformation and to provide an accurate recording of events prior to the accident and the subsequent administration of first aid.

Policy

Each school division should have written procedures for managing emergencies involving students, school personnel, and visitors. The school division staff should be knowledgeable about the emergency management procedure. Although true medical emergencies rarely occur in schools, the potential does exist. The school is responsible for the safety and well-being of students, staff, and visitors during school hours on school property or during school-sponsored activities. Therefore, local school division policies should address:

- Preventive measures to limit accidents and injuries.
- Policies to define what action will be taken when a serious injury or medical emergency occurs.
- Facilities and supplies to accommodate basic first aid and care of ill or injured student, staff member, or visitor.

Please refer to Code of Virginia Section 8.01-225. Persons rendering emergency care, obstetrical services, exempt from liability.

Procedure

- The school nurse/principal's designee is responsible for periodically monitoring the school environment for safety hazards and for auditing accident and injury reports to identify areas of high risk in the school. Areas identified as high risk should be assessed for causative factors and a report should be submitted to the principal for corrective action.

- School nurses should supplement the curriculum with classroom health lessons and individual health counseling as necessary, based on information derived from environmental monitoring and/or review of accident reports.

- Each school should have adequate health service facilities, supplies, and trained personnel to handle accidents, injuries, and/or sudden illness.

- The most recent edition of the flipbook First Aid Guide For School Emergencies should be readily available in the health room office of each school building. This guide contains a comprehensive listing of first aid measures needed to manage student, school personnel, and visitor emergencies.

- An emergency information card system for students should be maintained in the health room office. A similar system for staff members should be maintained following local school division policies.

- At least two full-time school building-based staff members must have successfully completed courses in cardiopulmonary resuscitation (CPR), Heimlich maneuver, and basic first aid.

  Note: Please see best practice recommendation described under "Best Practice" (at the beginning of this section).

- The teacher or other staff member to whom a student is responsible at the time an accident occurs should complete and file an accident report according to local school division policies.

- Staff members sustaining work related injuries should follow the appropriate guidelines for Worker's Compensation Insurance.

- Parents/guardians of students should be notified of all emergencies/injuries so that further observation/follow-up can be provided at home.

- All animal bites should be reported to the proper authorities after emergency care is given.

Extreme Emergencies

- All school personnel should be able to identify members of the response team and initiate the local school division's established system of triage for extreme medical emergencies.
- In extreme emergencies, the school principal or his/her designee may make arrangements for immediate hospitalization of injured or ill students, contacting parents/guardians in advance, if possible.
- The nurse and/or other designated school personnel, with the emergency information card, should accompany the student to the hospital and remain until the parent/guardian assumes responsibility.

Chronically Ill

- Individual health plans for chronically ill children should address potential emergency situations based on each student's health condition and provide precise instructions/physician's orders for specific treatments in certain defined emergency circumstances.
- Local school division policies for managing school emergencies should be reviewed and approved by a consulting physician, (i.e. school physician, private physician, local health department medical director or physician, members of the School Health Advisory Board.)

Report Forms

Please see the following samples of accident, injury, and emergency reporting forms that have been useful in school health programs either in Virginia or nationally:

- Henrico County Public Schools: Patron/Student Injury Report Form (Virginia)
- Fairfax County Public Schools: Pupil Accident Report Form (Virginia)
- Accident Report Form (Texas Education Agency)

- School Health Program: Accident Report (South Carolina Department of Health and Environmental Control)
- School Health Program: Head Injury Report (South Carolina Department of Health and Environmental Control)
- Accident Report (Colorado Departments of Education and Health)
- Emergency Call Card (Colorado Departments of Education and Health)
- Student Emergency Card (Texas Education Agency)

SAMPLE

Henrico County Public Schools
Patron/Student Injury Report Form

School name:

Date/Time of incident:

Location of incident:

Name of patron injured:

Name of student injured:

Person to contact regarding student injury (parent or guardian):

Witnesses (if any) to incident:

Nature of injury:

Did individual require medical treatment?

(If yes, who provided the treatment?):

Action taken by school:

☐ Sent to clinic

☐ Rescue squad called

☐ Physician called

☐ Parent contacted

Description of event leading to injury:

(If additional space is needed, add a sheet to this report.)

Name of person reporting incident:

Name of employee in charge at time of incident:

Signature of Principal

Date

DISTRIBUTION: *White* - Principal
Canary - Executive Director of Business Affairs

The proponent for this form is: **DIVISION OF BUSINESS AFFAIRS, Tel. 226-3820**
Stock No. 1301-126

FCSB-SAF 1 (7/91)

Fairfax County Public Schools

Student Accident/Injury Report Form

Complete this form within five days for all accidents/injuries *that result in* one or more of the following: 1) medical treatment by a physician (including emergency room) or dentist, whether taken for treatment by the school or parent; 2) one-half day or more missed from school; 3) indication by the parent/guardian that a claim will be filed against the school/school division; or 4) suggestion by the parent/guardian that the accident resulted from inappropriate actions/procedures by the school. Any information not available when the report is submitted (for example, days lost) shall be reported to the Safety Section as soon as available.

General

1. **Last Name** First MI
2. **Student ID Number**
3. **Date of Birth**
4. **Address** Number and Street City State Zip
5. **School Assigned** **School Code** _ _ _ _
6. **Sex** ☐ Male ☐ Female
7. **Grade/Special Program**
8. **Time Accident Occurred** Date Day of Week Exact Time ☐ a.m. ☐ p.m.

Injury

9. **Nature of Injury** (See reverse side)
10. **Body Part Injured** (See reverse side)
11. **Degree of Injury** ☐ Death ☐ Permanent ☐ Temporary
12. **Days Lost** From School
13. **Cause of Injury**

Accide

14. **General Location** (check one): ☐ School Grounds ☐ School Building ☐ To and From School ☐ Other Activities Not on School Property
15. **Specific Location** (See reverse side)
16. **Activity at Time of Injury** (See reverse side)
17. **Supervision** ☐ Yes ☐ No Name Position
18. **Equipment, Material, Animal, or Other Person Involved In Accident**
19. **Description** (explain who, what, when, why, and how)
20. **Witnesses**

Immediate Action Taken

21. **First Aid Treatment** ☐ Yes ☐ No By Whom ____ Position ____
    Explain
*22. **Taken to Physician** ☐ Yes ☐ No By Whom
    Taken to Dentist ☐ Yes ☐ No By Whom
*23. **Taken to Hospital** Name of Hospital Transported by: ☐ Private Car Driven by ____
    ☐ Yes ☐ No ☐ Rescue Squad
24. **Parents Notified** ☐ Yes ☐ No Time By Whom
25. **Other Action Taken by School**
    Repair Requested for ____ By Whom ____
    Telephone call to Work Order Section ☐ Yes ☐ No Date ____
    SSM 100 Submitted ☐ Yes ☐ No Date Other

Sign

26. **Report Prepared by** (signature and position)
27. **Date of Report**
28. **Local School Safety Chairman's Signature**
29. **Principal's Signature**
30. **Request Safety Inspection** ☐ Yes ☐ No
31. **Report Status:** ☐ Complete ☐ Incomplete

*Report medical treatment whether taken for treatment by the school or parent.

Distribution: *White—Director, Risk Management* *Canary—Safety Section* *Pink—School* *Goldenrod—Teacher*

9. NATURE OF INJURY

- Asphyxiation
- Amputation
- Bite (Note animal or human)
- Break/Fracture
- Burn (Note hot, cold, or chemical)
- Concussion
- Contusion/Bruise
- Cut/Abrasion
- Dental Injury
- Dislocation
- Electric Shock
- Infection/Inflammation
- Jammed/Crushed
- Nerve Injury
- Poisoning (internal)
- Puncture
- Sprain/Strain
- Sting
- Swelling/Bump
- Trauma Unspecified
- Vision Injury
- Other (specify)

10. BODY PART INJURED

- Abdomen
- Ankle
- Arm-Lower
- Arm-Upper
- Back
- Chest
- Ear
- Elbow
- Eye
- Face
- Finger
- Foot
- Genital
- Groin
- Hand
- Head
- Hip/Buttock
- Knee
- Leg-Lower
- Leg-Upper
- Mouth
- Neck
- Nose
- Ribs
- Shoulder
- Spinal Column
- Toe
- Tooth
- Wrist
- Other (specify)

15. SPECIFIC LOCATION

In Transit
- Leased Vehicle (field trip)
- Private Vehicle (field trip)
- School Bus
  - At bus stop
  - Loading/Unloading
  - On bus
- Walking Route-Off School Premises
- Walking Route-On School Premises
- Other-In Transit On School Grounds (specify)

Building-General
- Administrative Area/Office
- Auditorium/Theater-Specify exact location: auditorium/house stage/backstage, dressing room, control booth, catwalk, shop/production room, storage, other (specify)
- Cafeteria/Lunchroom
- Classroom (not lab or shop) Include parkos/trailer classrooms
- Clinic
- Doorway
- Exterior Landing/Step (attached to building)
- Gymnasium
  - Bleachers
  - Shower
  - Locker Area
  - Playing Floor
  - Other (specify)
- Hall
- Interior Entry Area (foyer)
- Library
- Locker (hall or commons area)
- Music/Choral/Band Room
- Pod Area
- Restroom
- Stair/Stairway
- Storage/Supply Room
- Weight Room
- Wrestling Room
- Other Building Area (specify)

Buildings: Labs and Shops
- Art
- Computer
- Cosmetology
- Home Economics
- Photography
- Science (specify)
- Vocational Education (specify)
- Other (specify)

Grounds
- Auxiliary Building (not parkos)
  Specify: storage, concession, ticket booth,-press box, other (explain)
- Bleacher
- Driveway
- Fence or Wall
- Lawn/Courtyard
- Parking Lot
- Playground-Apparatus
- Playground-Asphalt/Blacktop
- Playground-Other (specify)
- Playing Field (specify)
- Tennis Court
- Track
- Walks/Walk Steps
- Other-School Grounds (specify)

Other
- FCPS Facility-Non School
- Non-FCPS Facility
- Vocational Job Site

16. ACTIVITY AT TIME OF INJURY

Field Trip
- Day
- Overnight
- Overseas

Basic School Day
- Before/Between/After Class
- Class-Not Physical Education
- Lunch
- Recess
- Physical Education (specify sport/activity)
- Other School Day Event (specify)

Before/After School Day
- Cheerleading-Practice
- Cheerleading-At Game
- Club Sport Practice
- Club Sport Competition
- Extracurricular Activity-not athletic (specify)
- Interscholastic Athletic Practice (specify)
- Interscholastic Athletic Competition (specify)
- Intramural Sport/Game (specify)
- Travel To/From School (off premises)

Other (specify)

SAMPLE

Accident Report

To be filled in at the time of the accident by the person caring for an injured student who is referred to a doctor:

Student's name ____________________ Phone __________

Address ____________________ Age ______ Sex ______

Date ______________ Time ______________ Insurance ______________

Grade ______ Teacher ______________ School ______________

Location of accident ______________________________

Person in attendance ______________________________

Nature of Accident

- Abrasion
- Bruise/Bump
- Burn
- Cut
- Convulsion
- Dislocation
- Head Injury
- Fracture
- Laceration
- Puncture
- Shock
- Sprain

Other ______________________________

____

Part of Body Injured

- Abdomen
- Ankle*
- Arm*
- Back
- Chest
- Elbow*
- Eye*
- Face
- Finger*
- Foot*
- Hand
- Head
- Knee*
- Leg*
- Teeth
- Wrist*

Other ______________________________

____

*Left, right, both

How did it happen? ______________________________

____

____

____

Were parents notified? Yes ______ No ______

Treatment and disposition: ______________________________

____

Follow-up: ______________________________

Amount of time lost from school: ______________________________

(Signature) ______________________________
Principal, Teacher, or Nurse

Source: School Nurse Handbook. Texas Education Agency

SAMPLE

SCHOOL HEALTH PROGRAM

ACCIDENT REPORT

Name of Student: ______________________ Age: ________ Sex: ________

Grade: ________ Teacher: ________________ School: ______________

Date of Accident: ________________ Time: ________________

Location of Accident: ______________________________

First Responder: ______________________________

Place of Accident

- ☐ Classroom
- ☐ Hallway
- ☐ Bathroom
- ☐ Lunchroom
- ☐ Playground
- ☐ Gymnasium
- ☐ Other ________

Nature of Accident

- ☐ Abrasion/Cut
- ☐ Asphyxia
- ☐ Burn
- ☐ Fracture/Sprain
- ☐ Head Injury
- ☐ Laceration
- ☐ Other ________

Body Part Injured

- ☐ Abdomen
- ☐ Ankle
- ☐ Arm
- ☐ Back
- ☐ Chest
- ☐ Eye
- ☐ Face
- ☐ Foot
- ☐ Hand
- ☐ Head
- ☐ Knee
- ☐ Leg
- ☐ Teeth
- ☐ Wrist

Describe Accident: ______________________________

____

____

Describe Injury: ______________________________

____

____

Were Parents notified? ☐ Yes ☐ No

Describe treatment and disposition: ______________________________

____

____

____
Signature of Teacher, Principal
or Nurse

1 copy to Principal
1 copy to School Nurse

Source: School Health Program Manual. South Carolina Department of Health and Environmental Control, 1990.

SAMPLE

SCHOOL HEALTH PROGRAM

HEAD INJURY REPORT

Name of Student: ________________________ Date: __________

Homeroom: ________________________ Time: __________

School ________________________ Grade: __________

Dear Parent:

Your child received an injury to the head today at school. He/she was seen in the Health Room and had no problems at the time, but you should watch for any of the following symptoms:

1. Severe headache.
2. Nausea and/or vomiting.
3. Double vision, blurred vision or pupils of different sizes.
4. Bleeding, no matter how small, from the ear, nose or mouth.
5. Dizziness or disorientation.
6. Loss of consciousness or convulsion.

CONTACT YOUR DOCTOR OR EMERGENCY ROOM IF YOU NOTICE ANY OF THE ABOVE SYMPTOMS.

____
School Nurse

____
Phone

SOUTH CAROLINA
Healthy Children Learn Better
SCHOOL NURSES

Source: School Health Manual. South Carolina Department of Health and Environmental Control, 1990.

SAMPLE

Accident Report

Date ______________________________ Time ______________

Name ______________________________ Birth Date ________

Address ___________________________ Phone _____________

School ____________________________ Grade _____________

Teacher ____

Description of accident (include time and place) _____________

Name of adult present at time of accident _______________
Witness present at time of accident _______________

First aid given (describe) _______________

Time given _______________ By whom _______________

Time parent notified _______________ By whom _______________

Student was sent to: home ________ doctor ________ hospital ________

Days absent from school due to accident _______________

Follow-up information obtained _______________

Principal's signature _______________

School nurse's signature _______________

Other comments _______________

Source: Colorado School Health Guideline. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

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(front side of card) SAMPLE

EMERGENCY CALL CARD

Date____________________
School__________________
Grade___________________
Birth Date______________

Student's Name____
Last First Middle

Address______________________________________ Home Telephone_____________
City__________________________ Zip__________

TO PARENT OR GUARDIAN: To serve your child in case of ACCIDENT OR SUDDEN ILLNESS, it is necessary that you furnish the following information:

EMERGENCY CALLS	Name	Business Address	Business Telephone
Mother			
Father			

If not available, who else may we call for help? Other (1)______________________

Phone ________, (2)__________________ Ph. __________, (3)__________________ Ph. ________.

Health information: List any health conditions such as heart disease, diabetes, epilepsy, severe allergies, eye or ear problems, or any chronic condition, etc.

Explanation: ____

PHYSICIAN
1st choice________________________ 2nd choice ________________________
Phone number ______________________ Phone number ______________________

**IMPORTANT---PLEASE COMPLETE REVERSE SIDE OF CARD

(back side of card)

I, the undersigned, do hereby authorize officials of ________________________ School District to contact directly the persons named on this card, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event physicians, other persons named on this card or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

____________________________ ______________________________
Signature of Parent or Guardian

____
Student's Last Name First Initial

Source: Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

Student Emergency Card

Date ____________
School ____________
Grade ____________
Birth Date ____________

Student's Name ____
Last First Middle

Address ____ Home Telephone ____________
City ______________________________ Zip ____________

TO PARENT OR GUARDIAN: To serve your child in case of ACCIDENT OR SUDDEN ILLNESS, it is necessary that you furnish the following information for emergency calls:

	Name	Business Address	Business Telephone
Mother			
Father			

LIST TWO NEIGHBORS OR NEARBY RELATIVES WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED:

Name ____________________ Name ____________________
Address ____________ Tel ________ Address ____________ Tel ________

HEALTH INFORMATION: List any health conditions such as heart disease, diabetes, epilepsy, severe allergies, eye or ear problems, or any chronic condition, etc

Explanation: ____
____

DOCTOR: 1st choice ____________________ 2nd choice ____________________
Telephone Number ____________ Telephone Number ____________
HOSPITAL CHOICE: Address ____________________ Telephone Number ____________

IMPORTANT—PLEASE COMPLETE REVERSE SIDE OF CARD

Source: School Nurse Handbook. Texas Education Agency

Student Emergency Card

SAMPLE

Student Emergency Card

(Back of Emergency Card)

I, the undersigned, do hereby authorize officials of ______________________ School District to contact directly the persons named on this card, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

____
Signature of Parent or Guardian

____
Student's Last Name First Initial

MANAGEMENT OF DISASTERS

Legal Basis

Many of the laws governing the health, safety, and welfare of individuals may present requirements during management of disasters.

Recommendation

Definition

The American Red Cross defines a disaster as an occurrence such as a hurricane, tornado, storm, flood, high water, wind driven water, tidal wave, earthquake, drought, blizzard, pestilence, famine, fire, explosion, building collapse, transportation accidents, or other situations that cause human suffering or create human needs that the victims cannot alleviate without assistance.

An emergency is defined as any situation compromising the health, safety, or welfare of members of the student body or staff. Schools should furnish instructions for handling emergencies within a school

Rationale

School populations may be impacted by natural disaster, accidents, fires, or explosion. To insure minimal injury to students and staff, an emergency/disaster plan should be developed by each local school. This plan may be coordinated with the plan for the entire division and/or the county/city.

A comprehensive emergency/disaster plan should provide for:

- Protection of students and school personnel from injury.
- Isolation and containment of disaster.
- Restoration and/or maintenance of all operations within the school or command post/center.
- Protection of school property.

Procedure

Chain of Command for Disaster Management:

- Principal should be notified immediately.
- Central administration office should be notified.
- Staff involved in emergency plan for school should be notified.
- Police or emergency services officer should be notified.

Alert Procedures:

- All school emergencies should be reported to building principal immediately.
- The emergency plan should be implemented.
- The school nurse should be notified in order to identify health concerns and deal with the needs of the students and staff.
- Police and the emergency services officer should be notified, depending on the emergency.
- Faculty, staff, and students should be notified via the public address system.

Administrative Crisis Checklist

- Coordinate supervision at the scene.
- Determine proper response.
- Notify designated crisis personnel.
- Notify administrative staff
- Notify superintendent.

- Notify the emergency services officer, police, fire department, and/or rescue squad (if needed).
- Have the school nurse prepare for first aid and medical treatment.
- Arrange for visitors in the building to meet in designated area.
- Maintain control of school bell system.
- Maintain control of telephones.
- Secure all hallways and exits.
- Communicate to faculty, staff, and student body the nature of the emergency.
- Coordinate all communications with students, faculty, parents, central office, and media.
- Set up command post in or out of school depending on emergency/disaster.

References

- Fairfax County School System, 1991.
- State Emergency Response Plan.
- The American Red Cross Disaster Plan.

CRISIS INTERVENTION

Legal Basis

Several laws and policies may be involved during a crisis situation but will vary according to the nature of the crisis.

Recommendation

Introduction

Each school division should have a written plan for handling crisis situations within the school building, the school division, and the school community. The written plan should be readily available, and all staff should be familiar with its contents.

Over the course of a school year, incidents arise in schools and school divisions that require immediate, informed and effective response on the part of school staff. Most commonly, these incidents involve acts of violence, threatened assaults, death threats, terminal illnesses, and deaths. Somewhat less common are natural and/or accidental disasters. Incidents may occur within the schools, within a student's immediate family, or more generally, within the community served by the school.

Definition:

Use of the term "crisis" implies that an act or event affects the school community in such a way as to require immediate and effective response by the school staff.

Response is necessary to prevent harm or additional damage and to provide emotional support to students and staff.

Types of Events:

Crises that impact on the schools include suicides, suicide threats, natural and/or accidental deaths, medical emergencies and terminal illnesses. Such deaths or severe illnesses may occur within the student body, faculty, or staff, and may affect the entire school community. Other events that may have wide impact include fires, natural disasters, nuclear incidents, and random acts of violence. Gang fights and interracial hostilities can also erupt suddenly and in such a way as to affect the entire school.

Other events tend to affect individuals or small groups of students but they still require informed and sensitive response. These include situations involving a single student or the student's immediate family, such as the death of a close relative or friend.

Program:

A well-developed crisis intervention program has three phases: prevention, intervention, and postvention. Preventive activities are designed to avoid or minimize crises. The intervention phase consists of a series of procedures designed to cope with a crisis. Postvention entails dealing with the after-effects of a crisis.

Prevention

For students, crises may be averted by teaching the skills needed for problem solving, decision making, stress management, and other positive coping strategies. This instruction, including information to prevent substance abuse, suicide, and violence, can be modified for students in elementary school to high school as part of the emphasis on coping with normal developmental issues. These issues are already being addressed through programs such as DARE, SODA, peer counseling, and in the health curriculum. Please see Section III. Student Services: Prevention Programs and Section III. Prevention/Intervention of Substance Abuse. The examination and coordination of learning opportunities within each school may be helpful as a means of encouraging thoroughness and avoiding unnecessary duplication.

Students also benefit from a positive school atmosphere in which they have opportunities to participate in social, recreational, athletic, and other activities that assist students to develop competencies and self-esteem. It may be helpful for the school to cooperate with community agencies providing such activities. In addition, it may be possible to develop activities for students who are not involved and to reach out to them to elicit their participation.

For faculty and other staff, crises may be prevented or lessened in impact if there is inservice training to help identify and interact with students who are at risk for substance abuse, mental health crises, suicide, and violence toward others. Long-term benefits can be derived from training to help staff manage stress. Learning how to identify and deal with feelings about differences in race, class, and ethnicity can develop sensitivity needed within the school community. Efforts such as these serve to prepare the staff to respond effectively to crises or potential crises.

Developing a Crisis Intervention Plan:

The effects of crises and potential crises can be limited if there is a plan to deal with them before they occur. Such a plan helps to avoid hasty decisions, under-reaction, and over-reaction. Planning can substantially reduce trauma, stress, and disruption for students and staff. The core component of the crisis intervention plan is the establishment of a crisis intervention team in each school.

Duties of the Crisis Intervention Team:

- Developing school-wide procedures for responding to specific events such as death.
- Being available to assist when individual/group threats of violence arise.
- Coordinating responses to crisis situations, including:
    - Assistance in making referrals to appropriate sources,
    - Counseling with students as needed.
- Coordinating activities with area mental health and mental retardation services, and other community resources.
- Coordinating inservice activities for faculty with respect to identification of and response to suicide threats, substance abuse, physical abuse, and other critical life events.
- Assisting faculty responsible for implementing preventive curriculum.

When establishing the crisis intervention team, the principal should select staff members who will be in key positions to handle crisis, who respond well to crisis situations, who are not too busy to accept this responsibility, and who want to be on the team.

In addition to faculty, administrators, counselors, and school nurses, some schools have placed secretaries and custodians on the team. Psychologists and social workers, while itinerant, are vital members of the team.

The crisis intervention team's first task is to meet and to prepare a packet of information to be kept in the school office.

Suggested Contents of an Information Packet:

- A list of crisis intervention team members and their telephone numbers.
- A list of home telephone numbers of faculty and staff.
- A "telephone tree" showing how faculty and staff can be notified quickly.
- An accurate school map.
- Designation of rooms for individual and group counseling.
- Designation of staff to answer questions (by telephone and "walk-ins.")
- Designation of a staff representative to notify the superintendent (phone number.)
- Designation of a staff person to notify the administrator responsible for public information (phone number.)
- Designation of a family contact person.
- Designation of staff to be in the halls to give directions.
- Name tags for the crisis intervention team members.
- A copy of the bell schedule.
- A list of community resources/contacts with telephone numbers.
- A checklist of procedures to follow in the event of a crisis.

Other Crisis Intervention Team Activities:

- Provide faculty inservice training.
- Review crisis procedures with the faculty at the beginning of each school year.
- Establish regular meetings of the crisis intervention team to develop cohesiveness and update information and procedures.

Intervention

The crisis intervention team must develop a checklist of procedures to follow in the event of a crisis.

Suggested Checklist:

- The principal should:
  - ○ Verify facts.
  - ○ Establish calm, organized atmosphere.
  - ○ Notify crisis intervention team and set meeting.
  - ○ Notify the superintendent and the administrator responsible for public information when a death has occurred, including information on the nature of the death. The superintendent should communicate with and respond to the media. Local school decision policy will dictate the designated spokesman to the media at building level. Confidentiality of some information and family rights to privacy should be respected.

- The principal and team should:
  - ○ Organize school response (staff to be involved, rooms to be used, traffic flow).
  - ○ Notify staff, students, and parents.
  - ○ Announce funeral arrangements (if appropriate).
  - ○ Set time line for return to normal routine.
  - ○ Maintain communication to keep people informed and prevent unfounded rumors.
  - ○ Be sensitive to certain faculty members who may need supportive assistance.
  - ○ Assign counselors to individual and group rooms.
  - ○ Assist in the identification of those most likely to be affected (relatives, friends, associates, teachers).

- Identify other at-risk students.
- Monitor the counseling process including identification of those needing counseling.
- Establish referral system for counseling, whether individual or group.
- Continue to review information as it becomes available.
- Be available to provide counseling.
- Coordinate provision of counseling for faculty and staff, whether individual or group.
- Provide written statements, where appropriate, to faculty, students, and parents (only with approval of the principal).
- Assist with faculty debriefing at the end of the day to discuss the events of the day, the observed reactions of adults and students, and to solicit comments or additions to the list of high-risk students.

Please see Addendum A at the end of this section for a sample intervention flowsheet, Crisis Intervention Procedure Flowsheet.

When to Use the Crisis Intervention Team:

- General Considerations

  The principal may call a meeting of the school's crisis intervention team in response to any situation in which he or she thinks the team's consultation or intervention is needed. Such situations may include natural or accidental deaths, or suicide among students and their relatives and faculty or staff in the school. Other situations, such as a fire, natural disaster or school bus accident, might also result in intervention by the team.

- High-Risk Incidents

  In the event of a high-risk incident such as an armed intruder, an armed student, a hostage situation, discharging of firearms, chemical spills, or bomb threats, the principal should follow the procedures established for the local school division. When the involvement of police or other agencies in such incidents is completed, the principal may wish to call a meeting of the crisis intervention team to assist students, faculty, and parents as they respond to the incident.

- When A Death Has Occurred

The death of a member of the school community often will have a profound effect on the students and the school staff. When implementing counseling procedures, one needs to be particularly sensitive about those who were most closely associated with the person who died. There is also a need to be sensitive to varying attitudes toward death. Obviously, religious feelings are a factor. Less obvious are those situations where people have already experienced the recent death of a relative or friend or where relatives or friends are undergoing serious or terminal illnesses. Among children, attitudes toward death will vary with age and experience with death.

Please see Addendums B - E at the end of this section for information on the following topics:

- Reminder Sheet: How to Talk and Listen to Kids
- Children and Reactions to Death
- Grief In Children
- How Adolescents May Behave After the Suicidal Death of a Peer

- Debriefing

While the crisis intervention team may need to meet several times during the first day of the crisis, a debriefing meeting at the end of the day may be necessary. At this time, the events of the day should be reviewed, the effectiveness of the team's actions should be assessed, plans should be made for the next day(s), and a written report should be initiated.

Please see Addendum F at the end of this section for the following sample reporting form: Crisis Team Report form.

Postvention

There are many issues the crisis intervention team needs to consider after the first day of a crisis. If a student has died, students who have a written request from their parents should be released to attend the funeral. Staff should recognize that students who attend and those who do not attend the funeral may react to this event. Faculty should be reminded that some students may not be able to meet normal academic demands for varying periods of time. It may be important to check on absent students, especially those who are high-risk.

Depending on the situation, support groups for students, parents, and faculty may be continued for some time. Anniversary dates or holidays may be especially stressful times for some students and adults. Members of these groups may wish to develop a project or memorial to the deceased. This may be appropriate, but care must be taken to avoid "glorifying" the suicide of a student or making suicide appear to be an attractive option in any way.

When the school routine has returned to normal, the crisis intervention team should meet to review the events of the crisis, evaluate the team's performance, make any necessary modifications in procedures, and complete a report for the superintendent. The team members should be sensitive to their own stress reactions and to the continued stress for some members of the school community.

Suicide Awareness

The suicide rate among adolescents has risen dramatically during the past twenty years. Suicide is now the second leading cause of death for this age group. A great many factors have contributed to this alarming increase. Among these are: adolescents' lack of knowledge and skills in solving problems appropriately; their impulsiveness and lack of mature judgment; and their lack of experience with the emotional ups and downs of life. Addendums A - G at the end of this section contain suggestions for various ways that schools can reduce the risk of suicide among students. However, more specific information and procedures are available to intervene in preventing suicidal students from taking their own lives.

Very often, but not always, people who are suicidal give warning signs that they are about to kill themselves. Adolescents may exhibit such signs to another student, a teacher, a custodian, a secretary, or any other person at school. While appearing to most people to have no serious problems, adolescents may select one or two people with whom they confide their thoughts and plans about suicide. Because anyone at school may be in a position to observe warning signs, all members of the school community need to know these signs and how to respond to them.

All faculty and staff should be required to report any observed warning signs of suicide to a guidance counselor, school nurse, psychologist, or school social worker, all of whom are trained to work with suicidal students. They have the responsibility for following the best course of action in each case, using their professional judgment and expertise. The appropriate administrator for the above listed professionals should ensure that all newly hired members of these professions are qualified to intervene with suicidal students.

Inservice:

Please see Addendum G at the end of this section for the following sample outline: Youth Suicide Prevention Information For All Faculty and Staff. This outline could be used in an inservice program and distributed as reference material.

Each crisis intervention team should be responsible for including this information in an inservice program for all of the faculty and staff at its school. After this inservice has been given, principals should ensure that all newly hired or transferred faculty and staff have received such training.

Addenda

Please see addenda at the end of this section for the following sample crisis intervention forms/articles (from The Crisis Intervention Manual for Henrico County):

A. Crisis Intervention Procedure Flowsheet

B. Reminder Sheet: How to Talk and Listen to Kids

C. Children and Reactions to Death

D. Grief in Children

E. How Adolescents May Behave After the Suicidal Death of a Peer

F. Crisis Team Report

G. Youth Suicide Prevention Information For All Faculty and Staff

H. Bibliography

Reference

Henrico County Public Schools. The Crisis Intervention Manual for Henrico County.

Addendum A

CRISIS INTERVENTION PROCEDURE FLOWSHEET

School: ______________________________ Date: __________

Crisis Intervention Committee Members: ____
(list of those present)

____

Coordinator: ______________________________ Substitute: __________

Incident Description: ____

____

____

FIRST HOUR PROCEDURES

Additional information needed? Yes____ No____ Designated to: __________

School Administrators informed? Yes____ No____ Designated to: __________

Superintendent informed: Yes____ No____ Designated to: __________

of Public Information informed? Yes____ No____ Designated to: __________

Informational Statement prepared? Yes____ No____ Designated to: __________

Staff notified? Yes____ No____ Designated to: __________

Faculty meeting needed? Yes____ No____ Time: __________

Coordinated by: ______________________________ Place: __________

Bell schedule altered? Yes____ No____ Designated to: __________

CHECK PEOPLE NOTIFIED

Parents? Yes____ No____ Designated to: __________

Which Parent?: ______________________________
Method:

Police? Yes____ No____ Designated to: __________

Social Services? Yes____ No____ Designated to: __________

Mental Health? Yes____ No____ Designated to: __________

HELPING STUDENTS

Students informed? Yes____ No____ Designated to:____________

Method: Time:____________

Place:____________

High-risk students identified? Yes____ No____

Meeting arranged for high-risk students? Yes____ No____ Designated to:____________

Time:____________

Place:____________

Plan for long-range follow-up developed? Yes____ No____ Designated to:____________

FOLLOW-UP

Arrange faculty support meeting? Yes____ No____ Designated to:____________

Time:____________

Place:____________

Arrange Crisis Team support/follow-up meeting? Time:____________

Place:____________

Comments:

Addendum B

REMINDER SHEET

How To Talk And Listen To Kids

1. **Paraphrasing the presented content** (thoughts and/or feelings)

This is simply to paraphrase what the child has said in one's own words, and repeat it back to the child to test whether one has heard accurately. For example:

"What you're saying is . . . "

"Do you mean that . . . ?"

"So you feel that . . . "

2. **Reflecting the implications**

This requires going a bit beyond the manifest content of what the other person is saying, and indicating your appreciation of where the content is leading. For example:

"I guess if you did that, you'd then be in a position to . . . "

"So that might lead to a situation in which . . . "

"Would that mean that . . . ?"

3. **Reflecting the underlying feelings**

This technique brings into the open some of the underlying feelings that may be influencing the person to express himself the way he does. One tries to put oneself in the place of the person to experience how it must feel to be in their position. For example:

"I suppose that must make you feel rather anxious."

"If that happened to me, I'd be rather upset."

"You must have felt angry when that happened."

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NATIONAL
ASSOCIATION OF
SCHOOL
PSYCHOLOGISTS

Children and Reactions to Death

By Charles P. Heath
Deer Valley Unified School District
Phoenix, Arizona

• **Background**–Children must deal with the loss of significant others more often than most adults realize. Each loss results in the child going through the same process of grief resolution, though the length and intensity may vary. Loss is viewed as a cumulative process, in which, without complete resolution of a minor loss, subsequent less significant losses are likely to provoke similar stress. While exact figures are not known, it is estimated that five percent of the children in the United States (1.5 million) lose one or both parents by age 15.

Development–The child's level of cognitive development plays a primary role in the extent to which a child will understand the loss of a parent. Specific reactions as well as their duration are different for adults and children.

A child's need to ask the same questions about the death over and over is more of a need for reassurance that the story has not changed rather than a need for factual accuracy. Children also seek adult reactions so they can gauge their own reactions. Emotions may be expressed as angry outbursts or misbehaviors that are often not recognized as grief-related.

Developmental Phases in Understanding Death–These age references are not rigid but should be used as rough guides. Also, children may regress to an earlier stage when emotionally upset.

Infants & Toddlers: Prior to age 3 children are not able to achieve complete mourning. However, they do seem to explore the state of nonbeing by games such as peek-a-boo.

Three to Five: Children deny death as a formal event; death is seen as reversible. The dead are simply "less alive". The child seems to regard death mainly as a separation, a departure.

Four to Six: Children are prone to misinterpret superficial events as being intrinsically involved in death. For example, knowing someone who died in a hospital may make the child want to stay away from hospitals to avoid death. Prior to age seven, children use "magical thinking" where personal wishes, thoughts, and actions are believed to be the causes for what happens.

Five to Nine: This is the age when children begin to understand the finality of death. Death is seen as an accident rather than inevitable. One dies under certain circumstances and if those circumstances do not occur then one cannot die. Death is also seen as something that will happen to others, not to ourselves. Finally, for this age there is a tendency to view death as a person. The death-man is usually regarded as a creature of the night.

Ten to Twelve: Children have the mental development and emotional security to express an understanding of death as a final and inevitable event associated with cessation of bodily functions.

Adolescence: As the adolescent begins to gain more independence and starts looking toward the future, there is the realization that all future plans require time and death may come at any time to prevent these plans from reaching fruition. They realize that one grows up only to die.

• *From Handouts (1990), edited by Alex Thomas. A publication of the National Association of School Psychologists.*

Developmental Phases of Grief Resolution—These phases are the same for children and adults; they are not discrete phases and some overlap may occur; and the length and intensity of each phase is dictated by the seriousness of the loss.

Phase One: Characterized by shock and numbing followed by a reaction of alarm. The alarm is centered around questions of who is going to care for the child. Denial and disbelief may also be exhibited during this initial stage.

Phase Two: This time of acute grief is characterized by yearning, searching, disorganization, despair, and ultimately reorganization. This phase is also characterized by strong feelings of sadness, anger, guilt, and shame. Once the stage of intense feelings starts, it can take 6-12 weeks for the worst pain to subside and as much as two years before the grief process is completed.

Phase Three: This phase involves the integration of loss and grief where the child begins to reorganize daily activities. Less frequent and less intense crying is seen. The child is also able to verbalize an awareness of the loss.

What Can I Do as a Parent?—As a surviving parent there are several things which can be done to support the grieving child.

1. Explain the death in a clear and direct manner. If the remaining parent cannot do this, then the child should be informed by another adult who is close to the child.
2. The child should be told the dead person will never return and that the body will be buried in the ground or burned to ashes.
3. The remaining parent should not deny the child an opportunity to share in the expression of pain.
4. Adults should avoid using their children as confidants for their own comfort and understanding.
5. The single most important message to relay to the child is, "You are not alone; I am with you."
6. Touching and holding a child can do more than any words to relay a parent's message.
7. Children should be allowed to attend the funeral, if it is their wish.
8. Prior to the funeral someone should explain to children what is likely to take place, who will be there, and how people are likely to react.
9. The choice of whether to view or touch the deceased should be left up to the child.
10. It is important to establish continuity in the daily routines of children.
11. Changing to a new school or moving to a new neighborhood should be postponed.
12. If it is determined that a child is experiencing pathological grief, rather than normal grief reactions, counseling may be necessary in order to help facilitate the grieving process.

RESOURCES:

Grollman, E. (Ed.) (1967). Explaining death to children. Boston: Beacon. Information on both death and dying is presented by several professionals. Each discusses death based upon his or her background perspective.

Grollman, E. (1976). Talking about death: A dialogue between parent and child. Boston: Beacon. The narrator explains death to a child whose grandfather has died. This explanation is accompanied by a Parent's Guide which also lists agencies that may be of assistance.

Kopp, R. (1983). Where has Grandpa gone? Grand Rapids, MI: Zonderman. Discusses different aspects of death and grief including the function of funerals. Includes a special "read along" section for adults to read to children to help explain the meaning of death and ways to cope with the loss.

LaTour, K. (1983). For those who live: Helping children cope with the death of a brother or sister. Dallas, TX: Kathy LaTour. Designed to help with the readjustment by the family after the death of a child or sibling. Examines how surviving children react to the death of a sibling. Discusses problems that both parents and children are likely to encounter during the grieving process.

Manning, D. (1984). Don't take my grief away: What to do when you lose a loved one. New York: Harper & Row. Written more from the perspective of the bereavement of a spouse when losing a husband or wife. Assists in understanding what happens when someone dies, dealing in a realistic yet h[illegible]ing way with the necessity of accepting the loss and facing the feelings of loss, separation, and ev[illegible] guilt that we experience.

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Grief In Children

One of the most difficult tasks following the death of a loved one is discussing and explaining the death with children in the family. The task is even more distressing when parents are in the midst of their own grief.

Because many adults have problems dealing with death they assume children cannot cope with it. They may try to protect children by leaving them out of the discussions and rituals associated with the death. Thus, children may feel anxious, bewildered, and alone. They may be left on their own to seek answers to their questions at a time when they most need the help and reassurance of those around them.

All children will be affected in some way by a death in the family. Above all, children who are too young for explanations need love from the significant people in their lives to maintain their own security. Young children may not verbalize their feelings about a death in the family. Therefore, by holding back feelings because they are so overwhelming, they may appear to be unaffected. It is more common for them to express their feelings through behavior and play. Regardless of this ability or inability to express themselves, children do grieve, often very deeply.

SOME COMMON EXPRESSIONS OF CHILDREN'S GRIEF

Experts have determined that those in grief pass through four major emotions: fear, anger, guilt, and sadness. It should be remembered that everyone who is touched by a death experiences these emotions to some degree. Each adult and child's reactions to death are individual in nature. Some common reactions are:

SHOCK

The child may not believe the death really happened and will act as though it did not. This is usually because the thought of death is too overwhelming.

PHYSICAL SYMPTOMS

The child may have various complaints such as headache or stomachache and fear that he too will die.

ANGER

Being mostly concerned with his own needs, the child may be angry at the person who died because he feels he has been left "all alone" or that God didn't make the person "well."

GUILT

The child may think that he caused the death by having been angry with the person who died, or he may feel responsible for not having been "better" in some way.

REGRESSION

The child may revert to behaviors he had previously outgrown, such as bedwetting or thumbsucking.

SADNESS

The child may show a decrease in activity - being "too quiet."

It is important to remember that all of the reactions outlined above are normal expressions of grief in children. In the grief process, time is an important factor. Experts have said that six months after a significant death in a child's life, normal routine should be resuming. If the child's reaction seems prolonged, seeking professional advice of those who are familiar with the child (e.g., teachers, pediatricians, clergy, psychologist) may be helpful.

EXPLANATIONS THAT MAY NOT HELP

Outlined below are explanations that adults may give a child hoping to explain why the person they loved died. Unfortunately, simple, pat but dishonest answers can only serve to increase the fear and uncertainty that the child is feeling. Children tend to be very literal - if an adult says that "Grandpa died because he was too old and tired" the child may wonder when he too will be too old; he certainly gets tired - what is tired enough to die?

"Grandma will sleep in peace forever." This explanation may result in the child's fear of going to bed or to sleep.

"It is God's will." The child will not understand a God who takes a loved one because he needs that person himself; or "God took him bacause he was so good." The child may decide to be bad so God won't take him too.

"Daddy went on a long trip and won't be back for a long time." The child may wonder why the person left without saying goodbye. Eventually he will realize that Daddy isn't coming back and feel that something he did caused Daddy to leave.

"John was sick and went to the hospital where he died." The child will need an explanation about "little" and "big" sicknesses. Otherwise, he may be fearful if he or someone he loves has to go to the hospital in the future.

WAYS TO HELP CHILDREN

As in all situations, the best way to deal with children is honestly. Talk to the child in a language he can understand. Remember to listen to the child and try to understand what the child is saying and, just as importantly, what he's not saying. Children need to feel that death is an open subject and that they can talk about this subject when it arises. Below are just a few ways adults can help children face the death of someone close to them.

THE CHILD'S FIRST CONCERN MAY BE "WHO WILL TAKE CARE OF ME NOW?"

-- Maintain usual routines as much as possible.
-- Show affection, and assure the child that those who love him still do and that they will take care of him.

THE CHILD WILL PROBABLY HAVE MANY QUESTIONS AND MAY NEED TO ASK THEM AGAIN AND AGAIN.

- Encourage the child to ask questions and give honest, simple answers that can be understood. Repeated questions require patience and continued expression of caring.
- Answers should be based on the needs the child seems to be expressing, not necessarily on the exact words used.

THE CHILD WILL NOT KNOW APPROPRIATE BEHAVIOR FOR THE SITUATION.

- Encourage the child to talk about his feelings and share with him how you feel. You are a model for how one expresses feelings. It is helpful to cry. It is not helpful to be told how one should or should not feel.
- Allow the child to express his caring for you. Loving is giving and taking.

THE CHILD MAY FEAR THAT HE ALSO MAY DIE OR THAT HE SOMEHOW CAUSED THE DEATH.

- Reassure the child about the cause of the death and explain that any thoughts he may have had about the person who died did not cause the death.
- Reassure him that this does not mean someone else he loves is likely to die soon.

THE CHILD MAY WISH TO BE A PART OF THE FAMILY RITUALS.

- Explain these to him and include him in deciding how he will participate. Remember that he should be prepared beforehand, told what to expect, and have a supporting adult with him. Do not force him to do anything he doesn't feel comfortable doing.

THE CHILD MAY SHOW REGRESSIVE BEHAVIOR.

- A common reaction to stress is to revert to an earlier stage of development. (For example: a child may begin thumbsucking, bedwetting; or, may need to go back into diapers or have a bottle for a time). Support the child in this and keep in mind that these regressions are temporary.

Adults can help prepare a child to deal with future losses of those who are significant by helping the child handle similar losses through sharing their feelings when a pet dies or when death is discussed in a story or on television.

In helping children understand and cope with death, remember four key concepts: be loving, be accepting, be truthful, and be consistent.

Addendum E

HOW ADOLESCENTS MAY BEHAVE AFTER THE SUICIDAL DEATH OF A PEER

1. Display signs of needing to talk.

-- grouping before or after class and talking softly
-- somber mood, usually quiet
-- lingering after class

2. Disrupted peer relationships.

-- avoid the possibility of another loss
-- avoid the occasions of feeling the absence of the dead peer in usual groups or activities
-- avoid the feelings that relationships bring

3. Disrupted adult relationships.

-- blame adult for not being protectors
-- blame adults for causing the death
-- become overly dependent upon adults for safety
-- express ambivalence by fluctuating between angry outbursts and clingy dependency

4. Depression.

-- crying
-- loss of concentration
-- difficulty with school work
-- sleeping and/or eating disturbances
-- social withdrawal

5. React to shock in a variety of ways.

-- noisy and distracting in class
-- over zealous academically
-- denial of any relationship with the dead peer
-- over idealizing the dead peer and their relationship

6. Romanticize the idea of suicide and see it as an option for themselves.

-- may become fascinated with the subject of death through music, poetry, readings, writings.
-- may idealize the student and talk excessively about their relationship
-- may alter their style of clothing and mode of interacting
-- attitudes of "Who cares about life, we're all going to die anyway?"

7. Make a suicide attempt or engage in other self-destructive behavior.

-- increased alcohol and/or drug ingestion
-- reckless driving
-- criminal activity
-- running away or staying out late
-- suicidal ideas and attempts

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WHAT ADOLESCENTS MAY BE FEELING AFTER THE SUICIDAL DEATH OF A PEER

-- Shock

-- Guilt

-- Overwhelmed, Confused

-- Profoundly Sad

-- Anger (at adults for not preventing the death, at the peer for taking his/her life, at themselves)

-- Fear of Losing Self-Control

-- Suicide Now a Viable Option

-- Fear Over Their Own Vulnerability

-- Mourning Their First Major Loss

-- Loss of Omnipotence

-- Denial That The Death Was a Suicide

-- Awareness of The Dangerous Aspects in Their Own Lives

WHAT TEACHERS MAY BE FEELING AFTER THE SUICIDAL DEATH OF A STUDENT

-- Helplessness

-- Disbelief

-- Confused

-- Anger at the Student/Parents/Administration

-- Fear That it Might Occur Again

-- Fear of an Emotional Outbreak of the Surviving Students

-- Guilty

-- Denial - a Desire to Treat Life as Usual and Unchanged

-- Reflection About One's Own Children

-- General Feeling of Inadequacy

-- Sadness

-- Questioning of One's Profession and What Can Realistically Be Accomplished With Adolescents

Addendum F

CRISIS TEAM REPORT

DIRECTIONS: Maintain original for the principal's file, and send one copy to the Director of Pupil Services.

SCHOOL: ____________________ DATE OF REPORT: __________

STUDENT'S NAME: ____________________ D.O.B. __________

ADDRESS: ____________________ TELEPHONE NUMBER: __________

MOTHER'S NAME: ____________________ WORK NUMBER: __________

FATHER'S NAME: ____________________ WORK NUMBER: __________

GUARDIAN(S)/SUPERVISING AGENCY: ____________________

____

ADDRESSES OF ABOVE: ____________________

____

EMERGENCY CONTACT PERSON: __________ RELATIONSHIP: __________

ADDRESS: ____________________ TELEPHONE NUMBER: __________

PRESENTING PROBLEM: ____________________

____

____

DETAILED DESCRIPTION OF INCIDENT: (include date, time and place)

____

____

____

____

____

____

____

____

IMMEDIATE INTERVENTION BY CRISIS TEAM MEMBERS:

FOLLOW-UP PROCEDURES BY CRISIS TEAM MEMBERS:

FOLLOW-UP WITH PARENT(S), AGENCIES AND OTHERS:

Case Manager **Date**

Reviewed by:

Principal/designee **Date**

Addendum G

Youth Suicide Prevention Information

For All Faculty And Staff

Warning signs (to be considered in context and not behavior by itself)

1. Statements - Oral and Written
    a. direct - e.g., "I want to die." "I don't want to live anymore."
    b. indirect - e.g., "I want to go to sleep and never wake up."
    "They'll be sorry when I'm gone."
    "Soon this pain will be over."

2. Behavior
    a. depression, sadness, lack of energy
    b. changes in sleeping and eating habits
    c. drug/alcohol abuse
    d. impatience, impulsivity, inability to concentrate, listlessness and boredom
    e. angry, destructive boisterous behavior alternating to silent withdrawal or tearful loneliness
    f. withdrawal or loss of interest in social activities, hobbies, sports, job or school
    g. drop in grades by a good student or new concerns about grades by a poor student
    h. making "final arrangements" - giving away possessions, etc.
    i. risk taking, accident proneness
    j. a previous suicide attempt

Background Factors Increasing Risk

The precipitating event, such as the break up with a boyfriend or girlfriend, is often the last event in a life history of losses and difficulty coping and communicating including:

1. history of losses (death, divorce, moving, etc.)
2. suicide or attempt by family or friends
3. family alcoholism, marital conflict or poor communication
4. history of chronic illnesses, abuse or learning problems
5. difficulty with relationships which may be superficial or intense

What To Do If You Observe A Warning Sign

1. **Listen** if a student verbalizes despair or a wish to die
    a. Let them know you are listening - try to get time and space.
    b. Avoid "closed communication" leading to yes or no answers.
    c. Avoid giving advice, judging, reasoning with them or minimizing their pain.
    d. Be open and frank in asking about suicidal intent.

2. **Take it seriously and get help.**
    a. Confidentiality with a student cannot be kept if a life may be in danger; do not allow yourself to be sworn to secrecy.
    b. Your obligation is to inform a guidance counselor, school social worker or school psychologist without delay. All of these professionals are trained and experienced in responding to suicidal students.
    c. If a student has told you of his or her wish to die, do not leave them unsupervised while you get help.
    d. Remember, it is better to err on the side of caution than to risk responsibility for the death of a young person.

Addendum H

BIBLIOGRAPHY

Books of General Interest

A Parting Gift
Sharkey, Frances

A Special Kind of Love: Care for the Dying Child
Buckingham, Robert W.

Explaining Death to Children
Grollman, Earl A.

How it Feels When a Parent Dies
Krementz, Jill

Living and Dying
Lifton, Robert J.

Living with Dying: A Loving Guide for Family
Carroll, David

Should the Children Know?
Rudolph, Marguerita

Teaching Your Child to Cope With Crisis: How to Help Your Child Deal with Death, Divorce . . .
Ramos, Suzanne

Telling a Child About Death
Jackson, Edgar N.

The Child in His Family: The Impact of Disease and Death
The Child's Attitude to Death
Mitchell, Marjorie E.

The Dying Child
Easson, William M.

Where Has Grandpa Gone?
Kopp, Ruth L.

Books for Students

Kids' Book About Death and Dying

Learning to Say Good-bye When a Parent Dies
LeShan, Eda J.

Losing Someone You Love
Richter, Elizabeth

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Books for Students

When a Pet Dies
Rogers, Fred

About Dying
Stein, Sara Bennett

Available in your School Library or Community Library

Behind the Magic Line
(1969)

Broken Connection: On Death and the Continuity of Life
(1979)

Comforting Those Who Grieve
(1979)

Death as a Fact of Life
(1973)

Endings & Beginnings
(1980)

Endings: A Book About Death
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Facing Death
(1972)

Famous Last Words
(1961)

Final Mystery
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Grief Observed
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How Did They Die?
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How it Feels When a Parent Dies
(1981)

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(1985)

Letting Go With Love: The Grieving Process
(1984)

Available in your School Library or Community Library

Life and Death
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(1976)

On Death and Dying
(1969)

Questions and Answers on Death and Dying
(1974)

Readings in Aging and Death: Contemporary Perspectives
(1977)

Romeo Error
(1974)

Seven Wishes of Joanna Peabody
(1972)

Straight Talk About Death with Young People
(1975)

Talking About Death: A Dialogue Between Parent and Child
(1976)

Teen-ager and His Family
(1975)

Teenagers Face to Face with Bereavement
(1989)

Vital Signs: The Way We Die in America
(1974)

We Are But A Moment's Sunlight: Understanding Death
(1976)

Woman Said Yes: Encounters with Life and Death: Memoirs
(1976)

Films, Filmstrips

Available in your School Library or Community Library

Annie and the Old One (16mm film)
(1976)

Ciper in the Snow (video tape)
(1974)

Ciper in the Snow (16mm film)
(1974)

Coping with Death in the Family (sound filmstrip)
(1981)

Growing Old (video tape)
(1987)

Loss and Grief (sound filmstrip)
(1977)

Why Do We Die?
(1971)

ROLE OF THE SCHOOL NURSE IN CASE MANAGEMENT

Legal Basis

Some regulations that govern the delivery of services to students may dictate the use of case management services. Please see Section V. of this document, Public Law 101-476 (formerly P.L. 99-457).

Recommendation

Introduction

Case Management is a service function directed at coordinating resources to assure the most comprehensive program for meeting the needs of students with multiple, complex problems. The goals of this approach are (1) to provide quality care along a continuum of needs, (2) to empower students/families to become self-advocates, and (3) to reduce duplication or fragmentation of services and reduce costs.

Definition:

Although the definition of case management varies among the disciplines of mental health, social work, nursing, primary care medicine and others, all definitions of case management share common features.

Essentially, case management is a systematic process of identification and outreach, assessment, planning, service coordination, monitoring, evaluation, and advocacy through an approach that is responsive to the specific multiple and changing needs of individual clients and families.

Case Manager:

Selection of the case manager may be based on the primary problem that needs to be addressed; for example, financial and housing needs may indicate that the social worker should be the case manager, whereas, inability to identify, manage, and/or seek out help to maintain health may indicate that the nurse should be the case manager.

School Nurse Responsibilities

- Participating as a team member in the formulation of overall goals, plans, and decisions by interpreting medical data and identifying the impact on the educational environment.
- Serving as an advocate for the student and family.
- Assuming leadership in the individualized education plan (IEP) or the individualized family service plan (IFSP) when the primary service for the student is health related.
- Referring to community resources for needed services.
- Assisting in development of the 504 plan.
- Providing follow-up to assure that service needs are met.

Functions and Process of Case Management

Please see the diagram at the end of this section for a summary of the functions and process of case management (Figure 9).

References

Case Management Manual. Virginia Department of Health, Division of Maternal and Child, 1992.

American Nurses' Association. Nursing Case Management. Kansas City, Mo.: the Association, 1988.

Mundiger, Mary. "Community Based Care: Who Will be the Case Managers?" Nursing Outlook 3216 (Nov./Dec., 1984): 295.

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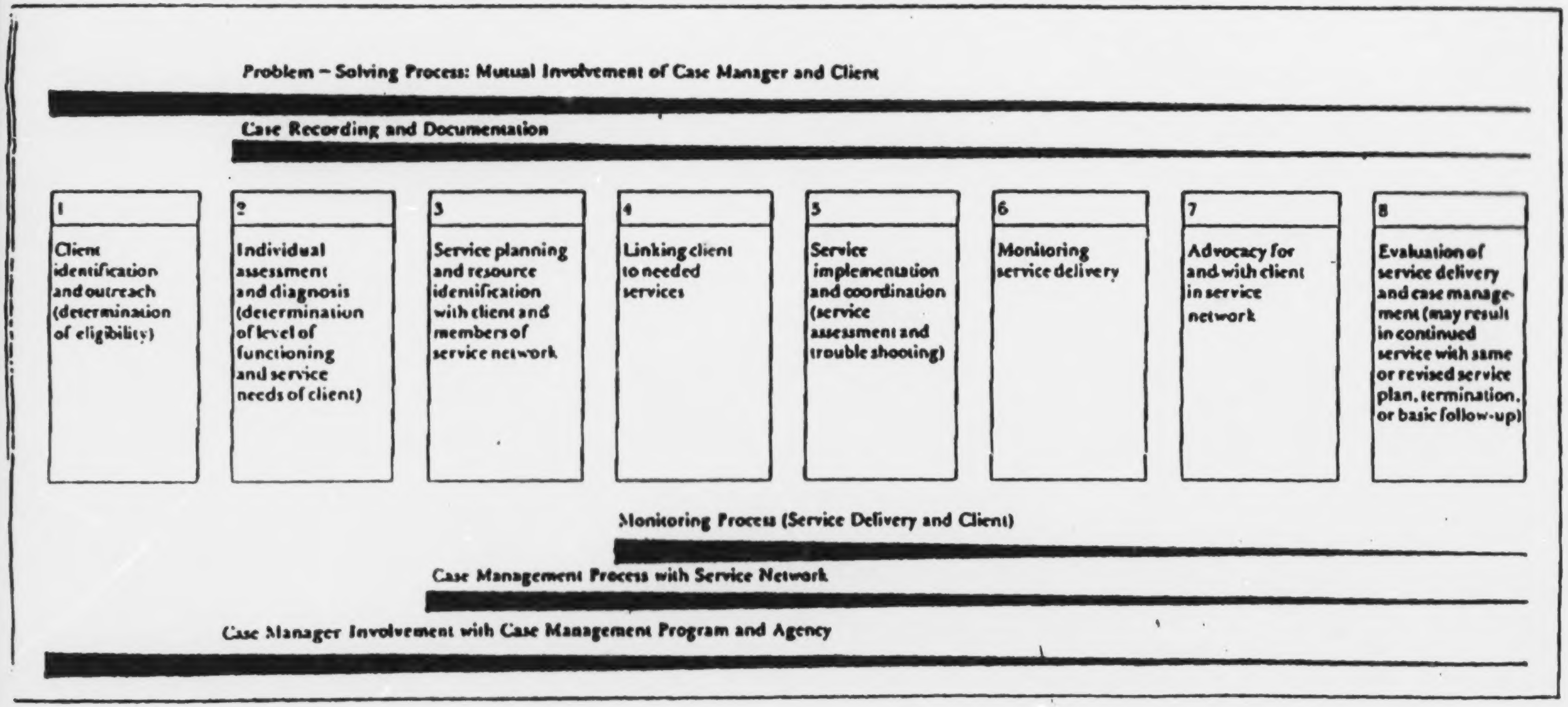
Problem – Solving Process: Mutual Involvement of Case Manager and Client
Case Recording and Documentation
1
Client identification and outreach (determination of eligibility)
2
Individual assessment and diagnosis (determination of level of functioning and service needs of client)
3
Service planning and resource identification with client and members of service network
4
Linking client to needed services
5
Service implementation and coordination (service assessment and trouble shooting)
6
Monitoring service delivery
7
Advocacy for and with client in service network
8
Evaluation of service delivery and case management (may result in continued service with same or revised service plan, termination, or basic follow-up)
Monitoring Process (Service Delivery and Client)
Case Management Process with Service Network
Case Manager Involvement with Case Management Program and Agency

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Figure 9

HOME VISITS

Legal Basis

Some regulations that govern the delivery of services to students may dictate the use of home visits. See Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia, effective July 1, 1990; amended August 1, 1991.

Recommendation

Introduction

Home visits made by members of the interdisciplinary team offer an excellent opportunity to foster communication between school and home. Advantages include convenience for the family, option for those families unwilling or unable to travel, family control of the setting, and a natural, relaxed environment for the discussion of concerns and needs.

Purpose

- Home visits afford the opportunity to gain a more accurate assessment of the student's family structure and behavior in the natural environment.
- Homes visits provide opportunities to make observations of the home environment and to identify both barriers and support for reaching family health promotion goals.
- The team member can work with the family first-hand to adapt interventions to meet realistic resources. Meeting the family on their home ground may also contribute to the family's sense of control and active participation in meeting the student's health needs.
- The home visit may be more than just an alternative setting for service; it may be an intervention modality.

Role of the School Nurse

During home visits, the nurse can:

- Establish rapport with the student's family support system.

- Assess family strengths and needs, including limitations and barriers to the student's achievements, the student's need for community health resources, and the student's behavior and reactions to home situations.
- In partnership with the family, plan school health services that promote and support family goals to maximize functional capabilities, including the student's self-care, independence, and future school attendance.
- Provide for family/student participation in health promotion, maintenance, and restoration, including providing information needed to make decisions and choices about using health care resources.

Preparation for the Home Visit

- Review available school and health records prior to home visit.
- Review current health care plans.
- Identify objectives for the visit.
- Contact attending physician, when appropriate, for questions and/or concerns.
- Plan time of visits to optimize safety and effectiveness.
- Make an appointment in advance of the visit.
- Log in and out at school office, noting the telephone number and address of the home to be visited, time of departure, and expected return.
- Wear name pin.
- Avoid going alone to neighborhoods known to be dangerous.

Procedure

- Explain purpose of the visit.
- Observe the home and surrounding environment, significant sociocultural influences, and interaction of family members.

- Identify health care needs/problems, based on subjective and objective data, and involve the family members in the process.
- List problems in order of importance in accordance with family perceptions.
- Discuss alternative solutions and available community resources.
- Make referrals as necessary to appropriate health care providers.
- Assist in the development of a plan for the appropriate interventions(s) and establish a time to evaluate the effectiveness of the plan.
- Share the plan with appropriate persons involved in the health care of the student.

Documentation

- Record problems identified, subjective and objective data, and plan of action including time line for achieving planned interventions.
- Include future plans and recommendations for home visits.

References

Stanhope, Marcia and Jeanette Lancaster. Community Health Nursing: Process and Practice for Promoting Health. St. Louis. Mo: The C. V. Mosby Company, 1988.

American Nurses' Association. Standards of Nursing Practice. Kansas City, Mo.: the Association, 1973.

School Health Program Manual. South Carolina Department of Health and Environmental Control, 1990.

NURSING SERVICES TO HOMEBOUND STUDENTS

Legal Basis

Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia, Effective July 1, 1990; Amended August 1, 1991.

Excerpt:

Children on Homebound Instruction

"Homebound instruction shall be deemed appropriate for a handicapped child only when such placement is stipulated in the child's IEP and is in accordance with the requirements of the least restrictive environment."

Recommendation

Introduction

Students with acute and chronic illnesses, severe injuries, medically high risk pregnancies, or recovering from surgery may require periods of homebound instruction. Though medical/nursing care will be provided by the private medical provider or a community agency, the school nurse may serve as a liaison between the school, family, and medical provider in planning for the transition from homebound status to school attendance.

Rationale

Extended absence from school contributes to desocialization, isolation, and potential dropout of students, especially those who have a chronic illness or are pregnant.

School nursing intervention is essential to facilitate appropriate case management of chronically ill or pregnant students and reduce absences caused by short-term illnesses.

Appropriate case management and coordination of services support the transition from homebound to school attendance.

Procedure

- When homebound instruction is deemed necessary, the school nurse will be notified by the appropriate school personnel.

- The school nurse contacts the family and student through telephone calls and home visits to assist the family in the utilization of appropriate community health care services.

- The school nurse interprets medical information for school personnel and assists the student in making the transition from hospital and/or home to school.

- Frequently it will be necessary to have a written health care plan that has been implemented prior to the student's return to school. This individualized plan is developed by a team consisting of the parents, student, physician, school nurse, school administrator, classroom teacher, homebound teacher and other appropriate personnel. The plan should be shared with all persons who interact with the student at school.

- Consult the Virginia Department of Education's Regulations Governing Education Programs for Handicapped Children and Youth in Virginia and Guidelines for Homebound Instruction.

References

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Guidelines for Homebound Instruction, Virginia Department of Education, July 1990.

ENROLLMENT OF MEDICALLY FRAGILE/UNSTABLE STUDENTS

Legal Basis

Public Law 93-112, Section 504 of the Rehabilitation Act of 1973.

Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia, Effective July 1, 1990; Amended August 1, 1991.

Recommendation

The entry of a child assisted by medical technology into the school setting presents a challenge to the family, student, and school staff. A medically safe and educationally sound program, accomplished by a collaborative effort, should create an environment that fosters academic success and social competence.

Distinction between Medically Fragile and Medically Unstable

Medically Fragile:

A Medically Fragile Child is one for whom environmental adjustments need to be made or facilities provided to assure comfort and maximum productivity.

Examples of medically fragile students include those with diabetes, asthma, cystic fibrosis, orthopedic impairments, cardiac abnormalities, pacemakers, seizure disorders, ostomy care, immune deficiencies, myelomeningocele, need for environmental adaptation, and planned assistance for environmental adaptation.

Medically Unstable:

A Medically Unstable Child is one who, without intervention or equipment or personnel, is at risk to him/herself or others due to pre-existing medical conditions.

Examples of medically unstable children include those with apnea, tracheostomy, care requiring frequent suction or treatment to avoid choking, need for mechanical ventilation, need for continuous oxygen for life-sustaining functions, and transmittable disease with biting and combative behaviors.

Medically unstable children should not be enrolled in class without appropriately designated personnel to take care of the child's medical need. It is recommended that the school board develop a policy for notifying in writing the parent of a medically unstable child that the educational system cannot guarantee the medical safety for these children. This notice should be signed by the parent who wants the child be in the classroom. It is recommended that this policy by defined and reviewed by the school division's legal advisor.

Prior to School Attendance

The following plan is intended to provide guidelines to ensure a smooth and successful transition into a public school setting for students with significant medical needs.

Medically Fragile Child:

- Early notification by the parent is beneficial when a student with medical need is to be enrolled or returned to school following hospitalization, etc.

- Necessary inservice training may be needed prior to the student's arrival or within a reasonable time after classes begin.

  For example:

  - Tube feeding
  - Blood sugar monitoring
  - Stoma care
  - Catheterization

- The principal or designee is to notify the school health coordinator or administrator responsible for student health services of the impending enrollment of a medically fragile student.

- Appropriate emergency plans and procedures should be adopted for student's care.

Medically Unstable Child:

- Early notification to the school is essential when a student with special health care needs is to be enrolled. While notification usually comes from the parent in the case of the child assisted by medical technology, the child's health care provider should also notify the school as soon as a medical need is obvious.

- Necessary inservice training must be provided and appropriate accommodations put in place prior to the student's arrival. Homebound instruction will be provided in the interim, if required.

- The principal or designee is to notify the school health coordinator or administrator responsible for student health services of student's impending enrollment as well as the special education specialist, if appropriate (i.e., student has active IEP).

- The receiving school is to obtain a signed Release of Information form between the school division and the child's physician and any previously involved health care facility.

- A planning meeting should take place within several days of the initial contact. The following personnel should attend:

    - Parent
    - Principal
    - School Health Coordinator
    - School Nurse
    - Special Education Director or Designee
    - Special Education Department Chair/Head Teacher (secondary level)
    - Guidance Counselor
    - OT/PT Department Chairperson
    - Transportation Representative
    - Others as appropriate (i.e., School Board Attorney, Social Worker, etc.)

- Issues to be discussed at this planning meeting include:

- Establishing protocol/standing orders, including emergency plans and procedures, as appropriate for the student's care.

- Accessibility issues (i.e., classroom, bathroom, cafeteria, scheduling, adaptive equipment).

- Establishment of inservice programs and/or staff development programs, as needed.

  For example:

  - CPR
  - Blood sugar monitoring
  - Ventilator care
  - Seizure
  - Suctioning
  - Stoma Care
  - Catheterization
  - Tube feeding

  Note: A minimum of two employees (based full time in the student's school building) must be trained in any necessary medical procedures.

- Examining the need for special support services (i.e., transportation, classroom paraprofessional, etc.).

Following Enrollment

Staff training should be updated with any changes in the student's health status or educational placement (at least yearly).

When initial training and implementation is completed, it is essential that these health care providers be evaluated at established regular intervals. This training and evaluation process must be documented.

HEALTH EDUCATION/PROMOTION

Legal Basis

Standards of Quality For Public Schools in Virginia. Board of Education, July 1990.

Recommendation

Schools may implement numerous health promotion activities to emphasize the importance of positive life-long health practices.

Role of the School Nurse

Health education is an essential part of the school nurse's role. Health education activities include health promotion, health counseling, and prevention. The nurse assists students, families, and groups to achieve optimal levels of wellness through health education; including classroom presentations, bulletin boards, newsletters, health fairs, and individual or family health counseling. School nurses serve as a resource for the health education curriculum by providing current, appropriate information. They also may be used as teachers in the classroom or serve as consultants for the classroom teacher.

The school nurse assists the faculty and staff by working with established health and wellness programs, including substance abuse, weight control, smoking cessation, stress reduction, aerobic exercise, and blood pressure screening or testing for cholesterol.

School nurses serve the community in programs such as support groups and screening programs. They are available to interpret school health services and the role of the school nurse to the community.

Reference

American Nurses' Association. Standards of School Nurse Practice. Kansas City, Mo.: the Association, 1983.

HEALTH COUNSELING

Legal Basis

Health counseling may be a part of the delivery of required health services for students.

Recommendation

Introduction

Health counseling implies a one-to-one communication between a health professional and a student, parent, or staff member. It generally centers around a person with a health problem such as asthma, diabetes, adolescent pregnancy, or seizure, and includes health maintenance, providing information and support in coping with illness and disability, and consumer options for making health care choices.

The distinction is made between health counseling and health education in which groups of children receive general health information to assist in decision making.

Health counseling should be provided to students identified through the health appraisal process or referred by the principal, teacher, parents, self, or other school personnel.

Purpose

Health counseling will:

- Provide an understanding climate in the school for counseling and guidance for students and parents.
- Provide health information regarding growth and development, sexuality, family life, and respect for one's body.
- Provide referral and resource for staff and students with actual or potential health problems to seek medical care as soon as possible.
- Encourage school attendance and/or homebound instruction based on medical advice.

- Encourage students and families to use community resources to furnish needed services beyond the scope of the school.

- Provide prenatal and postnatal health counseling of students.

PREVENTION PROGRAMS

Legal Basis

Some of the following programs have a legal basis. For further information, please contact the Virginia Department of Education.

Recommendation

The following are examples of programs and or initiatives provided by the Department of Education:

- The Health Education Standards of Learning Objectives

  This comprehensive health education program is designed to provide students with information to help them make positive decisions about all areas of health and wellness.

- Family Life Education

  A program that is part of the comprehensive health education program.

- AIDS Education

  A program included in the comprehensive health education program.

- School Dropout Prevention

  This program provides resources to prevent school dropouts.

- Youth Risk Prevention

  Youth Risk Prevention is a Department of Education effort to promote positive self-esteem and a safe and healthy community/school environment. Particular emphasis is on the prevention of alcohol and other drug use by youth. Related emphasis is on seat belt safety, suicide prevention, and safe school climate.

  The Youth Risk Prevention program includes the following initiatives:

  - ○ Youth Alcohol and Drug Abuse Prevention Project (YADAPP) Conference

- Drug Abuse Resistance Education (DARE)
- Operation Prom/Graduation (OPG)
- School/Community Team Training Institutes
- Drug-Free Schools and Communities Act of 1986 (Title V) Administration
- Resources, Training and Consulting
- SODA/Peer Helper Program Development and Manual
- Crises Affecting Youth Training
- Alcohol and Other Drug Policy Conference
- Regional Commonwealth Alliance for Drug Rehabilitation and Education (CADRE) Conferences
- Drug-Free Schools Recognition Program
- Safe Schools/Violence Prevention
- Youth Risk Prevention Resource Guide
- LET'S TALK STRAIGHT - Newsletter
- Wheeler Award
- Safe Homes Project
- I AM ALWAYS SPECIAL Curriculum K-1 and 6-10
- Tobacco/Steroid Use Prevention
- Male Adolescent Curriculum
- Self-esteem Teleconferences
- Student Assistance Program Training
- Youth Risk Prevention Dissemination

- ○ Parent Education Training Model

Local school divisions may provide programs and student support groups on the following topics. The programs and support groups are designed to aid students who share similar needs and concerns, and may provide education for the school staff, parents, and other students.

- Chronic diseases (i.e., asthma, diabetes, spina bifida, cystic fibrosis, sickle cell, seizures, hemophilia, terminal illness)
- Eating disorders (i.e., anorexia, bulimia)
- Pregnancy
- Parenting
- Divorce, single parents, blended families
- Substance use/abuse by students and/or family members
- Health and wellness
- Grief/death and dying
- Self-respect

PREVENTION/INTERVENTION OF SUBSTANCE ABUSE

Legal Basis

Drug Free Schools and Communities Act of 1986. Funds available from U.S. Department of Education.

Recommendation

Substance abuse in the school setting is addressed as a part of the health services program for students. For example:

- Substance Abuse Counselors

  Employment of substance abuse counselors varies with school divisions; they may be full-time, part-time, itinerant, special contract, or they may be provided by interagency agreement.

- Intervention

  Immediate intervention is available to students in several school divisions. Often the counselor, substance abuse counselor, social worker, nurse, psychologist, or mental health worker is available.

- Prevention Initiatives and Programs

  These programs take many forms, including one-time motivational speeches, specialized instruction in the classroom and in short-term groups, programs sponsored by school divisions, and collaborative interagency initiatives such as involvement with CADRE (Commonwealth Alliance for Drug Rehabilitation and Education), and several local, state, regional, and national conferences.

- Intervention Programs

  Intervention programs for students focus on improving skills in decision-making, problem-solving, interpersonal communication and relations, and goal setting. The programs vary within school divisions in terms of scope and length. Some focus on students who have been suspended for violating substance abuse policies of schools and

- Classroom Instruction, Special Curricula and Special Projects

  Classes integrate instruction about substance abuse wherever possible, and opportunities exist for students to have special projects on substance abuse; example: I AM ALWAYS SPECIAL curriculum.

- Special Independently Sponsored Programs

  Some programs are available in the school setting because of the sponsorship or a special agency or group: examples include: DARE (Drug Abuse Resistance Education) Program, PULSAR, SADD, and MADD.

RISK MANAGEMENT

LEGAL LIABILITY ISSUES

Legal Basis

Please consult the following for laws, regulations, statutes, and standards, relating to school health:

- Code of Virginia
- Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia. Effective July 1, 1990; amended August 1, 1991.
- Management of the Student's Scholastic Record in the Public Schools of Virginia. Commonwealth of Virginia, Department of Education, Revised 1989.
- Standards for Accrediting Public Schools in Virginia. Commonwealth of Virginia, Department of Education, July 1988.
- Standards of Quality For Public Schools in Virginia. Board of Education, July 1990.

Recommendation

The incidence of lawsuits, in general, has increased over the past 20 years. It is important for administrators, teachers, nurses, and all staff to be aware of potential liability and to actively practice "risk prevention".

Periodic inservices or opportunities to attend programs on legal issues should be made available to increase awareness and understanding. Communication and coordination with the state or local risk management department is advised.

The doctrine of sovereign immunity is recognized in Virginia. Sovereign immunity protects school boards, and some governmental employees in some of their functions. Protection is provided when the employee is performing within the scope of employment, as authorized or directed. Whether a particular action will fall under sovereign immunity will depend on the facts of the case, however, sovereign immunity only applies to negligent actions, not intentional or malicious actions.

Negligence is the careless failure to do what a reasonable person would do. In education and child care, the most common negligence suits arise from accidents on playgrounds, in industrial arts, in physical education, and in transporting students.

In most instances schools carry insurance protecting their employees from suit for negligence. Liability insurance alleviates two burdens. It will pay any ultimate judgement or settlement, and it will provide a lawyer to defend the case. Since attorneys' fees often exceed the judgement or settlement, insurance is essential.

Another type of suit, akin to medical malpractice claims, can arise when educators perform roles best left to medical and quasi-medical professionals. Many states have held unqualified or underqualified teachers liable for attempting to diagnose psychological problems, learning disorders, or similar conditions. To date, however, there are no Virginia cases on this issue.

It is crucial for staff to have a clear understanding of their roles and responsibilities, and to receive adequate training to fulfill these responsibilities.

Risk prevention or risk management practices include:

- Documentation
- Education and training for staff
- Being alert to "product notices", attending to warning labels that accompany equipment or products
- Being alert to trends and taking steps to prevent future occurrences; the school notices that a particular piece of physical education or playground equipment is involved in accidents/injuries
- Follow the risk management department's guidance about notifying the insurance carrier after serious accidents, injuries, or untoward events
- Do not discuss accidents, injuries or untoward events with the public. Do not discuss with lawyers unless authorized to do so by your state or local legal counsel.

Reference

"Legal Liability Issues Involving Teachers, Schools and Day Care." A memorandum by John A. Gibney, Jr. of Shuford, Rubin, Gibney & Dunn, Richmond, Va.

RECORDS

DOCUMENTATION

Legal Basis

Please refer to those items listed under Section IV. of this document, Risk Management: Legal Liability Issues.

Recommendation

Documentation is an essential component of school health services. It is imperative that each person providing health services to a child document the care given, including accidents or injuries, first aid measures, medications and treatments provided, and any other interventions.

Categories of Records

An appropriate documentation system includes three categories of records:

- A record of activities required by law, including immunization data, mandated physical examinations, and screening reports (vision and hearing and other screenings).
- A record of student assessments and interventions, such as clinic visits for illness or injury, nursing assessments of chronic health conditions and health care plans.
- Hospital and medical records requested for health and educational planning.

Tips:

- An ongoing individual student health record should be part of every school health program. The record should accompany the student as he progresses through the grades and should be considered part of the cumulative record. The health record should be maintained as part of that record when the student transfers, withdraws, or graduates from school.

- The documentation system should be simple enough for people to understand it. Furthermore, it must include pertinent information; this information is critical from a risk management standpoint. "Documentation wins lawsuits. Memory loses lawsuits".

  Reference:

  "Legal Liability Issues Involving Teachers, Schools and Day Care." A memorandum by John A. Gibney, Jr. of Shuford, Rubin, Gibney & Dunn, Richmond, Va.

- The statute of limitations for injured children in Virginia extends from the date of injury until the child's twentieth birthday. Accurately remembering specific events over a period of time is not possible, and frequently, witnesses cannot be found at the time of trial. Therefore, appropriate documentation is an essential component of risk management.

Injuries and Accidents

Documentation for injuries and accidents should contain the following information:

- Student's name, date, time, and location of accident; the equipment or product involved, if any; names of adult witnesses and people in charge.
- Brief description of accident.
- Brief description of injuries.
- Action taken, care provided.
- Names of people to whom child was entrusted, such as rescue squad.
- Time and method of notifying parents.

Accident report forms should be developed to meet local reporting needs.

Please see Section III. of this document, School Health Services: Special Health Services - Management of Student/Staff Visitor Emergencies.

Resources

The following resources are recommended as valuable tools for developing the documentation system for the school district:

- Management of the Student's Scholastic Record in the Public Schools of Virginia. Commonwealth of Virginia, Department of Education, Richmond, Virginia 23216-2060.

  This manual describes the responsibilities of the local educational agency, the management and content of the scholastic record, access to records, disclosure, directory information, category I and category II files, and retention.

- Guidelines for School Nursing Documentation: Standards, Issues, and Models. National Association of School Nurses, Inc., Lamplighter Lane, P.O. Box 1300, Scarborough, Maine 04070-1300.

  This manual was developed to assist school nurses in understanding and applying the principles of nursing documentation in the school setting. Samples of different types of forms utilized across the country are provided.

- "School Health Records: Nursing Practice and the Law." Schwab, N. and Gelfman, M., School Nurse, April 1991.

  This article describes the diversity of federal and state laws that affect record keeping in public schools; and describes documentation methods that protect student/family confidentiality while minimizing the nurse's and school district's liability.

- Standards of School Nursing Practice, American Nurses' Association, 2420 Pershing Road, Kansas City, Missouri 64108.

  This booklet presents the nationally accepted standards of practice for school nursing, which includes data collection, diagnosis, planning, intervention, and evaluation. The standards also address professional development, interdisciplinary teamwork, and research.

CONFIDENTIALITY

Legal Basis

Family Educational Rights and Privacy Act of 1974 (FERPA).

Management of the Student's Scholastic Record in the Public Schools of Virginia. Commonwealth of Virginia, Department of Education, revised 1989.

Note:

Health records are subject to the Family Educational Rights and Privacy Act of 1974 (FERPA). The fundamental requirement of FERPA is that every school district receiving federal funds for any program must publish a records policy and annually notify parents and students over 18 years of age about this policy. The policy must meet certain standards as defined by the act:

- Records concerning individual students, containing "personally identifiable information", are not released by the school without written parental consent or consent from students over age 18.
- Parents and guardians of students under 18, and students over 18, have the right to inspect all school records concerning that student.
- The school division record maintenance system must be described in sufficient detail so that parents will be able to locate each place where their child's student records may be found.
- School division staff members with access to student records must be identified by names and position.
- Each student's file must include a record of access, on which all school staff members must sign whenever they consult that student's file (see Management of the Student's Scholastic Record in Public Schools in Virginia, Section 8.3 A).
- Parents have the right to appeal anything in a student's file that they consider inaccurate, misleading or in violation of the student's rights of privacy or other rights; and, if the school district is unwilling to delete such challenged material, the parent may request a hearing, provide a written statement to be attached to the challenged material (see

Management of the Student's Scholastic Record in Public Schools in Virginia, Part VI amendment procedure).

- The school division must define what constitutes "directory information" (student name, ID#, etc.), under what circumstances that information may be released without parental consent, and how a parent may have "directory information" concerning his or her child protected from release.

However, treatment records "...made or maintained by a physician, psychologist, or other recognized professional or paraprofessional acting in his or her professional capacity..." and used in the treatment of an "eligible student", that is, a student over the age of 18 years of age or any student in an institution of post secondary education, are excluded from the definition of "educational records" in FERPA and are not automatically accessible to student (34 CFR § 99.3 b. 4.).

An exception to parental access is provided for "personal notes," which are defined as "not education records". Personal notes refer to notes generated by one school staff member for his or her own use. By definition, such personal notes are also not accessible to any other school staff member except a substitute for the original author of the note. According to FERPA, the school nurse may keep "personal notes" about services provided to an individual student so long as the nurse does not share those notes, or the contents of the notes, with anyone else except a nurse who substitutes for him or her. "Substitute" may apply to the nurse's supervisor if the supervisor is a nurse who may be responsible for providing services when the school nurse is absent.

Recommendation

Recording Guidelines

Accurate maintenance of health records is a legal and professional necessity. The school district should have clearly established procedures for carrying out this responsibility.

- Documentation should be objective and should contain essential information, not a subjective interpretation.

- Documentation should include any nursing action taken or any health care provided for a student.

- Entries should be written by the person who provided the care; it is not acceptable to write or sign for someone else.

- Each entry should have a date and time and the full legal signature (i.e., Ann Smith, R.N.).
- Entries should be legible and written in ink. Black ink is best for legibility over time and for clarity if records must be duplicated.
- Correct spelling and standard abbreviations should be used.
- If mistakes are made, draw a single line through the mistake, write "Error" above it; sign and date directly above. Erasures, "whiting-out," or scratching out, etc. is not permitted.
- Record complaint or symptoms in student's own words and use quotation marks.
- Recording should be current and late entries should be avoided. If a late entry is necessary, it must follow the correct date and time sequence (write today's date and time when entering a note for yesterday and mark it "late entry for" and indicate yesterday's date).
- Do not leave blank lines on notes; draw a line through the center of empty lines or parts of lines.

SAMPLE RECORDS AND FORMS

Legal Basis

Please refer to those items listed under Section IV. Risk Management: Legal Liability Issues.

Recommendation

Please see the following sample records and forms that have been useful in school health programs either in Virginia or nationally. Copies of the Virginia records and forms are located in Section VIII. of this document, Virginia Forms. Copies of the other records and forms are located at the end of this section.

Virginia Records and Forms:

- School Entrance Physical Examination and Immunization Certification (MCH-213C). See Section III. Services: Health and Physical Assessment - School Entrance Physical Assessment.
- School Entrance Health Information Form (Form HPE-h12 12/83). See Section III. Services: Health and Physical Assessment - School Entrance Health Information Form.
- Cumulative Health Record (Form LF.009 5/88).
- Virginia Physical Inspection of Students: Notice Sent By Teachers or Nurse to Parents (Form No. HPE -h-9-125M 4/83).

Other Records and Forms:

- School Information Sheet

  Provides basic identifying information about location of supplies and names/phone numbers for key contact persons in the school.

- Emergency Care Information

Contains basic locator information for parents and other persons to contact in the event of an emergency; parents are to send this information to the school annually, provides an area for parents to alert the school about health conditions of the student.

- Multi-Purpose Referral Form

  Used by school personnel to refer health issues to the nurse; is a mechanism for the nurse to provide a written response.

- School Health Assessment Summary or Special Education Annual/Triennial Review

  Used to obtain health information, summarize health records sent to the school for special ed annual or triennial review.

- Students Referred for Special Education Staffing

  Used as a worksheet or tracking record.

- School Health Problem List

  Used as an individual health record to identify major health problems and action plans.

- Progress Notes: Teacher's Observations, Discussions With Parents, Physician's Recommendations, Nurse's Reports, Etc.

  Used to record contacts and interventions with an individual student and others regarding the student.

- Authorization For Release of Information Form: To School District and From School District

  Used to release information to or from the school.

- Classroom Record Worksheet

  Used as a worksheet for screening programs.

- Clinic Card/Card Supplement

  Used to record clinic contacts with an individual student, including date, time, nature of illness, care given, disposition of case, and signature of care giver.

- Daily Treatment Log

  Used to record all clinic contacts within a given day, including date/time, procedure notes, observations, and students' names.

- Medication Chart

  Used to record medication information on any student receiving medication, including the medication order, date, amount (pill/liquid), time, and signature of person administering the medication.

- Permission for Medication

  Used to permit the administration of medication to individual students, includes medication information and signatures of physician and parent or guardian.

- Audio Screening Worksheet

  Used to log and track audio screening follow-up information.

- Vision Screening Worksheet

  Used to log and track vision screening follow-up information.

- End of Year PHN Statistics

  Used to compile annual vision and audio screening statistics, including total numbers of students who failed each screening, were seen by a doctor following the referral, whose parents refused to follow-up with medical evaluation, and who moved.

SCHOOL INFORMATION SHEET

GENERAL INFORMATION:

SCHOOL: ____________________

SCHOOL NUMBER ________ TELEPHONE NUMBERS ____________

ADDRESS AND DIRECTIONS ____________________

____

____

PRINCIPAL(S) ____________________

SUBSCHOOL PRINCIPALS ____________________

SECRETARY(S) ____________________

GUIDANCE ____________________

CLINIC AIDE ____________ HOURS ________

PSYCHOLOGIST ____________ DAY ________

COUNSELORS ____________ DAY ________

SOCIAL WORKER ____________ DAY ________

HEALTH CHAIRMAN ____________ TELEPHONE ________

SPECIAL PROGRAMS IN SCHOOL ____________________

____

ENROLLMENT ____________________

HEALTH DATA INFORMATION:

LOCATION OF AHDFs ____________________

LOCATION OF HE-1s ____________________

LOCATION OF MEDICATION ____________________

LOCATION OF EMERGENCY CARE CARDS ____________________

LOCATION OF CLINIC CARDS ____________________

LOCATION OF SUPPLIES ____________________

LOCATION OF SCREENING INFORMATION AND SUPPLIES ____________

____

VOLUNTEER ROSTER ____________________

____

Source: Fairfax County Health Department

SAMPLE

EMERGENCY CARE INFORMATION

Student Legal Name

LAST ____ FIRST ____ MI ____ SCHOOL ____

DATE OF BIRTH: __/__/__ SSN: ___-__-___ SEX: MALE FEMALE

LANGUAGE SPOKEN AT HOME: ____

FATHER	**ADDRESS**	**TELEPHONE**
LAST ____	____	home ____
FIRST ____	____	work ____
MIDDLE ____	____	car/pager ____
MOTHER	**ADDRESS**	**TELEPHONE**
LAST ____	____	home ____
FIRST ____	____	work ____
MIDDLE ____	____	car/pager ____
LEGAL GUARDIAN	**ADDRESS**	**TELEPHONE**
LAST ____	____	home ____
FIRST ____	____	work ____
MIDDLE ____	____	car/pager ____

Student resides with ____ FATHER ____ MOTHER ____ LEGAL GUARDIAN

EMERGENCY CONTACT INFORMATION **(If parent/guardian unreachable)**	**BEFORE AND AFTER SCHOOL CARE** **(Complete if applicable)**
NAME OF EMERGENCY CONTACT ____	**NAME OF PROVIDER** ____
TELEPHONE NUMBER (___) ____	**TELEPHONE NUMBER** (___) ____

Source: Fairfax County Public Schools

ADDITIONAL INFORMATION

INSURANCE INFORMATION

Name of Insurance Company

Policy/group/employee number

HMO number, if applicable

PHYSICIAN INFORMATION

Name of Physician

(___)____________________

Telephone number

MEDICAL INFORMATION (Check all that are applicable)

____allergy to food or medicine

__________ ________

__________ ________

____asthma

____bee sting

____cardiac, be specific

____diabetes

____digestive, be specific

____

____handicapping condition

____hemophilia

____respiratory, be specific

____

____seizures

____other, please list

____

____

____

List all medical conditions for which your child receive continual care:______________________________

____

List all medications and dosages your child receives on a continual basis:______________________________

____

____

Signature parent/legal guardian

Date

SS/SE-5 (Rev. 12/86)

Fairfax County Public Schools
Department of Student Services and Special Education
Fairfax, Virginia

MULTI-PURPOSE REFERRAL FORM

REFERRAL TO:
☐ Local Screening Committee ☐ Other

Student Last First MI		Date of Birth
School		Parent
Teacher		Address Number and Street
Counselor		City State Zip
Grade	ID No.	Telephone: Mother (H) (W) Telephone: Father (H) (W)

STATEMENT OF CONCERN (Describe as specifically as possible the nature of your concern and actions taken to date.)

Signature of Referral Source ____ Relationship to Student ____ Date ____

DISPOSITION:
☐ Referral forwarded to local screening committee *(Do not complete remainder of this form.)*
☐ Other *(Complete remainder of this form.)*

Complete this portion ONLY if OTHER is checked under Disposition

DESCRIBE RESPONSE TO REFERRAL INCLUDING ACTIONS TAKEN

Signature ____ Title ____ Date ____

Following case disposition, COPIES to:
Area file, as appropriate
School file, as appropriate
Principal or director of guidance, as appropriate

"SCHOOL HEALTH ASSESSMENT SUMMARY"
OR
"SPECIAL EDUCATION ANNUAL/TRIENNIAL REVIEW"

Student ______________________________ Birth Date ________

School ______________________________ Grade ____________

Review of School Health Records: (Record any past medical problems that are of Significance.)

Chronic health problem(s):

Significant health history from original assessment:

Significant health history since last staffing:

Current Findings or Concerns: (Record current health history and assessment information).

Vision: ____________, Date ____________, Hearing: ____________, Date ____________
Height: ____________, Percentile ________, Weight: ____________, Percentile ________

Current medications:

Current health status: (include chronic as well as acute)

Nursing Comments: (State present level of physical functioning in educator term)

Recommendations: (List health needs in educator terms)

Date ______________________________ School Nurse ____________________

Source: Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

STUDENTS REFERRED FOR SPECIAL EDUCATION STAFFING

NAME	GRADE	SCHOOL	PARENT'S NAME	DATE NOTIFIED	HEALTH ASSES. DONE	STAFFING DATE	COMMENTS

Source: Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

SAMPLE

SCHOOL HEALTH PROBLEM LIST

NAME:		DOB:
DATE	PROBLEM TITLE	INACTIVE PROBLEM OR RESOLVED
	1. ______________ PLAN:	
	2. ______________ PLAN:	
	3. ______________ PLAN:	
	4. ______________ PLAN:	
	5. ______________ PLAN:	
	6. ______________ PLAN:	

Source: Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

PROGRESS NOTES: TEACHER'S OBSERVATIONS, DISCUSSIONS WITH PARENTS, PHYSICIAN'S RECOMMENDATIONS, NURSE'S REPORTS, ETC.

CODE: TNC - Teacher Nurse Conference; HV - Home Visit; TC - Telephone Call; OV - Office Visit

DATE	PROB. NO.	NOTES	SIGNATURE	TITLE

Source: Adapted from Colorado School Health Guidelines. Colorado Departments of Education and Health, Second Edition, 1986.

AUTHORIZATION FOR RELEASE OF INFORMATION TO SCHOOL DISTRICT

I, ______________________________ hereby authorize
(Parent or legal guardian)

______________________________ to release the following

information pertaining to ______________________________
(Name)

Birthdate: ______________________________

Specify information: ______________________________

____

____

____

Send to:

______________________________ ______________________________
Signature Witness

______________________________ ______________________________
Date Date

AUTHORIZATION FOR RELEASE OF INFORMATION FROM SCHOOL DISTRICT

I, ______________________________ hereby authorize
(Parent, legal guardian, or self - if at lease 18 years of age)

______________________________ School District to release

the following information pertaining to ______________________________
(Name)

Birthdate: ______________________________

Specify information: ______________________________

____

____

____

Send to:

______________________________ ______________________________
Signature Witness

______________________________ ______________________________
Date Date

Source: Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

GRADE ____________________

CLASSROOM RECORD WORKSHEET

TEACHER ____________________

Name	Immunization	Distance Vision			Near Vision			Cover Test	Tracking	Color	Vision Recheck			Referred	Hearing		Hearing Recheck		Referred	Scoliosis	Referred	Comments
		Both	Rt	Lft	Both	Rt	Lft				Both	Rt	Lft		Rt	Lft	Rt	Lft				

Source: Colorado School Health Guidelines. Colorado Departments of Education and Health, Second Edition, 1986.

SAMPLE

SAMPLE

(Front of card)

Fairfax County Public Schools
CLINIC

Name of Student ______________________________
Last First Middle Initial

Date of Birth ______________________________

Name of Parent or Guardian ______________________________
Last First Middle Initial

Date Month-Day-Year	Time		Nature of Illness, Care Giver, Disposition of Case. Signature of Care Giver
	In	Out	

Form 7 (7/86)

(Back of card)

Date Month-Day-Year	Time		Nature of Illness, Care Giver, Disposition of Case. Signature of Care Giver
	In	Out	

Form 7 (7/86)

SAMPLE

NAME

(Front of card)

Date Month-Day-Year	Time		Nature of Illness. Care Giver. Disposition of Case Signature of Care Giver
	In	Out	

NAME:

(Back of card)

Date Month-Day-Year	Time		Nature of Illness, Care Giver, Disposition of Case Signature of Care Giver
	In	Out	

Form 7A (2/86) Clinic Card Supplement

DAILY TREATMENT LOG

Name: ______________________ School: ____________

Procedures: ______________________________________

Parent: ______________________ Phone: ____________

Date/Time	Procedure Notes	Observations	Name

Source: Fairfax County Public Schools

To be completed on any student receiving medication

MEDICATION CHART

Name: ____________________

Medication Order: ____________________

Date	Amount Pill/Liq	Time	Signature	Date	Amount Pill/Liq	Time	Signature

Source: Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

Permission for Medication

Name of student ______________________________

School ______________________ Grade ______________

Teacher ______________________________

Medication __________________ Dosage ______________

Purpose of medication ______________________________

____

Time of day medication is to be given ______________________

Possible side effects ______________________________

____

Anticipated number of days it needs to be given at school ____________

____

Date ______________________ ______________________
Signature of Physician

I hereby give my permission for ______________________ to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication.

Date ______________________ ______________________
Signature of Parent or Guardian

Note: The prescription medication is to be brought to school in a container appropriately labeled by the pharmacy, or physician, stating the name of the medication and the dosage.

Source: Colorado School Health Guidelines. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

AUDIO SCREENING [illegible]KSHEET

SCHOOL: ______________________ PHN: ______________________
SCHOOL YEAR: ______________________

STUDENT, PARENT'S NAME AND PHONE NUMBER	GRADE	TEACHER/PERIOD	RETEST	COMMENTS	CALLED PARENT	LETTER SENT	UNDER CARE	NOT UNDER CARE	MOVED, TRANSFERRED	RECORDED	CORRECTION RECORDED	HE-1

Source: Fairfax County Health Department, Virginia

7/82 (Rev. 03/90)

VISION SCREENING WORKSHEET

SCHOOL: ____________________ PHN: ____________________

YEAR: ____________________

STUDENT, PARENT'S NAME AND PHONE NUMBER	GRADE	TEACHER/PERIOD	WITHOUT GLASSES		GLASSES HOME/BROKEN		LAST EXAM.	NEXT APPT.	COMMENTS	CALLED PARENT	LETTER SENT	UNDER CARE/ CORRECTED	NOT CORRECTED	MOVED, TRANSFERRED	AHDF		HE-1
			R	L	R	L									RECORDED	CORRECTION REQUESTED	

SAMPLE

Source: Fairfax County Health Department

END OF YEAR PHN [illegible]ATISTICS

VISION SCREENING

Name of School	1 Failed Screening	2 Under Care	3 No Correction Parent Refusal	4 No Correction Financial	5 Moved
Totals					

AUDIO SCREENING

Name of School	1 Failed Screening and Referred	2 Under Care	3 No Correction Parent Refusal	4 No Correction Financial	5 Moved
Totals					

INSTRUCTIONS

Failed Screening: Total number students failed and referred.
Under Care: Total number seen by the doctor following the referral.
No Correction/Parent Refusal: Total number students whose parents refuse to follow up with medical evaluation.
No Correction/Financial: Total number whose parents refuse to follow-up with medical evaluation and give financial hardship as a reason.
Moved: Moved from school.

NOTE: Column 1 = Columns 2 + 3 + 4 + 5

SAMPLE

Source: Fairfax County Health Department

STUDENTS WITH SPECIAL NEEDS

HISTORICAL PERSPECTIVE

Legal Basis

In 1970 Congress passed the **Early Education for Handicapped Children Program**, providing seed money for the development and operation of experimental, demonstration, and outreach preschool and early intervention programs for handicapped children. This was the federal government's first major effort in early intervention.

In 1973 Congress passed **P.L. 93-112**, the **Rehabilitation Act of 1973**. **Section 504** is the basic civil rights legislation prohibiting discrimination against the handicapped; **Section 504** applies only to those who receive federal funds.

In 1974, to assure appropriate education opportunities for children with special needs, Congress passed **P.L. 93-380** the **Education Amendments of 1974** which guaranteed due process and provision of education in the least restrictive environment.

In 1975 Congress passed **P.L. 94-142,** the **Education of all Handicapped Children Act** (EHA). This law requires all states to provide a "Free, appropriate public education" to school-age children with handicaps in the "least restrictive environment." Section 619 provided incentives to states to serve handicapped children aged 3 to 5.

- Under this law, "handicapped children" are defined as those who are mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, or orthopedically impaired, other health impaired (OHI), or who have specific learning disabilities, and who by reason of these handicaps require special education and related services.

- "Related services" which includes school health-related services are among those services which must be provided to sustain these children's attendance. These services are described in P.L. 94-142 and include among others, nursing; physical, occupational, and language therapy; modification of classroom schedules; and, if necessary, actual physical alterations of the school.

- The law stipulates that children shall be taught in the "least restrictive environment." This has been interpreted to mean that, if at all possible, the child should be in the regular classroom with normal children.

In 1983, believing that it was time to try to encourage states to expand services to preschool children, infants, and toddlers with handicaps, Congress passed **P.L. 98-199**. That legislation set aside money for planning, development, and implementation grants dealing with the preschool population; allowing states to apply for grants to provide services to disabled children age 0 through 3. In the first quarter of 1985, 20 states received such grants.

In 1986 Congress enacted **P.L. 99-457,** the **Education of the Handicapped Act Amendments of 1986**. This legislation amended the Education of all Handicapped Children Act (EHA) to, among other things,

- replace the preschool grants program authorized by P.L. 94-142 with a new program (Part B, Section 619) for children with disabilities, ages 3 through 5, and

  [Note: The term "children with disabilities" means mentally retarded, hard of hearing, deaf, speech or language impaired, visually handicapped, severely emotionally disturbed, orthopedically impaired, or other health impaired, or children with specific learning disabilities, who by reason thereof require special education and related services. 20 U.S.C. Section 1401 (a)]

- create a new state grant program (Part H) for infants and toddlers with handicaps, birth through age 2, and their families.

  [Note: The law defines "handicapped infants and toddlers" as children from birth through age 2 who require early intervention services because they "(A) are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: Cognitive development, physical development, language and speech development, psychosocial development, or self-help skills, or (B) have a diagnosed physical or mental condition which has a high probability of resulting in developmental delay." 20 U.S.C. Section 1472]

In October of 1990 Congress passed **P.L. 101-476**, which reauthorized the Education of all Handicapped Children Act (EHA), Parts C through G, through fiscal year 1994, changed its name to the **Individuals With Disabilities Education Act** (IDEA), and made minor changes to Part H and Part B.

Purpose

The purposes of Public Law 94-142 (EHA), Public Law 99-457, and Public Law 101-476 (IDEA) are:

- To guarantee the availability of special education programming to children with disabilities, ages 3 to 21 inclusive (Virginia has extended this to ages 2 to 21).
- To assure fair, appropriate decision making about providing special education to children with disabilities.
- To establish management and auditing requirements and procedures.
- To provide federal financial assistance to state and local governments.

References

American Academy of Pediatrics. School Health: A Guide for Health Professionals. Elk Grove Village, Ill.: the Academy, 1987.

Educating Children with Handicaps: A Guide to P.L. 94-142 and P.L. 99-457. A Scriptographic booklet by Channing L. Bete Co., Inc., South Deerfield, Mass.: 1989.

NEC*TAS Financing Workbook: An Interagency Process for Planning and Implementing a Financing System for Early Intervention and Preschool Services. National Early Childhood Technical Assistance System, January 1991.

Silverstein, Robert. "The Window of Opportunity: P.L. 99-457." In The Intent and Spirit of P.L. 99-457: A Sourcebook. Washington D.C.: National Center for Clinical Infant Programs: Project Zero to Three, February 1989.

PUBLIC LAW 94-142: EDUCATION OF ALL HANDICAPPED CHILDREN ACT (1975)

Legal Basis

Please see Section V. of this document, Students With Special Needs: Historical Perspective.

Background

"Public Law 94-142, the Education for all Handicapped Children Act, was passed by Congress in November 1975 and implemented in October 1977.

The major provisions of P.L. 94-142 call for:

- Free, appropriate, public education for all disabled children ages 3 through 21.
- Identification and evaluation of all disabled children, regardless of the severity of their disabilities. An individualized education plan (IEP) must be provided for each, and reviewed at least once a year.
- Special education provided in the 'least restrictive environment'.
- Safeguards to ensure parents due process in the identification, evaluation, or placement process.
- State responsibility for insuring that disabled children placed in private schools by the state receive special educational service at no cost to parents, and that the children are afforded the same rights as children in public schools.
- Mandatory, state-sponsored inservice training for general and special education personnel and support staff.
- The establishment of programs to develop public awareness of resources for the disabled." (1)

Definitions

Handicapped Children:

" 'Handicapped children' means those children evaluated, in accordance with these regulations, as being mentally retarded, hard of hearing, deaf, speech or language impaired, autistic, visually impaired, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf-blind, severely and profoundly handicapped, multihandicapped, or having a specific learning disability, who, because of these impairments, need special education and related services." (2)

Specific Learning Disability:

" 'Specific Learning Disability" means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or to do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include children who have learning problems which are primarily the result of visual, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural, economic disadvantage." (2)

Determining Eligibility:

Two criteria are established for determining eligibility under this act. First is whether the student has one or more of the listed disabilities. Second is whether the child requires special education and related services.

Related Services:

" 'Related services' means transportation, and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education, and includes speech pathology and audiology, psychological services, physical, and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes.

The terms also included school health services, social work service in schools, and parent counseling and training. Senate Report No. 94-168 provides a definition of "related services," making clear that all such related services may not be required for each individual child and that such term includes early identification and assessment of handicapping conditions and the provision of services to minimize the effects of such conditions.

The list of related services is not exhaustive and may include other developmental, corrective, or supportive services (such as artistic and cultural programs, and art, music and dance therapy), if they are required to assist a handicapped child to benefit from special education." (2)

[Note: Above is written as one paragraph in the regulations.]

Special Education:

" 'Special Education' means specially designed instruction, at no cost to the parent, to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions." (2)

Individualized Education Program (IEP):

This act mandates education in the least restrictive environment, and establishes the individualized education program (IEP) as the management tool.

" 'Individualized Education Program' (IEP) means a written statement for each handicapped child developed in any meeting by a representative of the LEA [Local Educational Agency] who shall be qualified to provide, or supervise the provision of, specially whenever appropriate, such child, which statement shall include:

1. A statement of the present levels of educational performance;

2. A statement of annual goals, including short-term instructional objectives;

3. A statement of the specific education and related services to be provided, and the extent to which such child will be able to participate in regular educational programs;

4. The projected date for initiation and anticipated duration of the services; and

5. Appropriate objective criteria and evaluation procedures and schedules for determining, at least on an annul basis, whether instructional objectives are being achieved." (2)

Best Practice:

Best practice is to include personnel representing the disciplines that will provide related services and/or are able to interpret specific information, such as the nurse.

Resources

Further information is available from the following resources:

- Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia, Effective July 1, 1990, Amended August 1, 1991. Virginia Department of Education, Division of Special Education Management Programs, P.O. Box 6-Q, Richmond, Virginia 23216-2060.

- No. 196 Public Law 94-142, Section 504, and Public Law 99-457: Understanding What They Are and Are Not, Joseph Ballard, Bruce A. Ramirez, and Kathy Zantal-Wiener, Revised 1987, 16 pp. 1-9 copies $5.50 each. Available from The Council for Exceptional Children, 1920 Association Drive, Reston, VA 22901.

References

(1) American Academy of Pediatrics. School Health: A Guide for Health Professionals. Elk Grove Village, Ill.: the Academy, 1987.

(2) Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia, effective July 1, 1990; amended August 1, 1991.

PUBLIC LAW 101-476: INDIVIDUALS WITH DISABILITIES EDUCATION ACT (1990)

FORMERLY PUBLIC LAW 99-457: EDUCATION OF THE HANDICAPPED ACT AMENDMENTS OF 1986

Legal Basis

Please see Section V. of this document, Students With Special Needs: Historical Perspective.

Overview

"The Individuals With Disability Education Act (formerly Education of the Handicapped Act) was amended in 1986 with legislation designed to help states establish a statewide, comprehensive system of early intervention services for infants and young children with special health care needs and their families. This legislation, P.L. 99-457, mandates services for children beginning at age three with the option to provide services for children who are developmentally delayed or at risk for developmental delays from birth through the second year of life.

This bill established a national policy on early intervention which provides assistance to states to build systems of service delivery, and recognizes the unique role of families in the development of their handicapped children (Congressional Record, 22 September 1986, P.H. 7904). With the advent of P.L. 99-457, Congress provided opportunities for all eligible young children and their families to receive the benefits of early intervention and pre-school services.

In addition, the realistic assumption was made that no one agency, group or discipline could meet the needs of children with special needs and their families. Therefore, multidisciplinary collaboration and interagency coordination were mandated." (1)

Part H

Public Law 99-457 added a new program (Part H) to encourage states to plan, develop, and implement early intervention services to infants and toddlers with developmental delay and their families. States participating in the Part H program were permitted five years (1988-1993) to develop programs to provide appropriate services to eligible children and their families.

The goals of Part H are as follows:

- To develop and implement a statewide, comprehensive coordinated, multidisciplinary, interagency program of early intervention services for handicapped infants and toddlers and their families.
- To facilitate the coordination of payment for early intervention services from federal, state, local and private sources (including public and private insurance coverage).
- To enhance states' capacity to provide quality early intervention services and expand and improve existing services.

Early Intervention Services

Early intervention is service that can begin at birth and is designed to facilitate the process of development as well as enhance the family's capacity to meet the child's special needs. These services are tailored to meet the unique needs of children with developmental delays and their families.

Some early intervention services include:

- Case management services
- Family training, counseling, home visits
- Health services necessary to enable the infant or toddler to benefit from the other early intervention services
- Occupational therapy
- Physical therapy
- Psychological services
- Social work services
- Speech/Language pathology
- Audiology

Services are to be provided at no cost to the family unless the state plan includes provision for payment.

Major Players in Implementing P.L. 101-476

- The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has been designated as Virginia's lead agency for Part H.
- The Virginia Interagency Coordinating Council (VICC) meets to advise and assist the lead agency in performing its responsibilities. VICC members are appointed by the governor and include a representative from the major state agencies that are engaged in providing services for children with handicapping conditions, parent representatives, and community members.
- Each county has a local coordinating council usually composed of representatives from the public school system, community services board (mental health), health department, and social services. Public agency staff work closely with private providers who are involved with individual families.

Components That Must be Offered

As of October 1991, Virginia was participating at the fourth-year level, which means that the following components must be available:

- Service coordination (case management)
- Multidisciplinary assessment
- Individualized family service plan (IFSP)
- Procedural safeguards

Service Coordination

The responsibility for service coordination can be assigned to personnel from any of the public agencies. Plans have been developed by the local coordinating council to indicate specific responsibilities of the coordinator and time frames for response.

Individualized Family Service plan (IFSP)

The Individualized Family Service Plan (IFSP) is an interagency plan describing the strengths and needs of the child and family.

Multidisciplinary Assessment

The IFSP team is composed of professionals, and is based on the needs of the child and family members. The team must have a minimum of two disciplines (health, mental health, education, etc.) and a family representative. The family may participate to the extent that they wish to be involved.

Procedural Safeguards

Procedural safeguards, or guidelines, are developed by DMHMRSAS and VICC. Part H safeguards closely follow those outlined by the Department of Education for Part B for such components as due process rights, parent access to records, privacy and translation into the primary language of the family.

Changes

The following are some of the P.L. 101-476 changes identified by the U.S. Department of Education:

- The term "handicapped" is replaced by the term "disability." The general definition of children with disabilities is expanded to include children with autism and traumatic brain injury.
- A new section is added that waives the states' 11th Amendment constitutional immunity from suits in federal court for violation of the EHA.
- Services for deaf-blind children and youth are expanded to include programs for early intervention and the transition from school to work and independent living.
- An information dissemination program is continued through the establishment of centers in each state that provide parents with training and materials on special education.

- Early intervention programs are to be developed to address the needs of children prenatally exposed to maternal substance abuse.
- Greater emphasis is placed on meeting needs of ethnically and culturally diverse children with disabilities.
- A new program is established to serve children and youth with serious emotional disturbances.
- A grant program is authorized to promote the development and use of assistive technology devises and services. (2)

Reference

(1) National Standards of Nursing Practice for Early Intervention Services. University of Kentucky College of Nursing grant "Leadership Development for Nurses in Early Intervention," draft October 1991.

(2) VICC (Virginia Interagency Coordinating Council) Bulletin, Winter 1991.

RELATED SERVICES

Legal Basis

See Section V. of this document, Students With Special Needs: Historical Perspective

Definitions

Related Services:

" 'Related services' means transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education, and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes.

The term also includes school health services, social work services in schools, and parent counseling and training. Senate Report No. 94-168 provides a definition of "related services" making clear that all such related services may not be required for each individual child and that such term includes early identification and assessment of handicapping conditions and the provision of services to minimize the effects of such conditions.

The list of related services is not exhaustive and may include other developmental, corrective, or supportive services (such as artistic and cultural programs, and art, music and dance therapy), if they are required to assist a handicapped child to benefit from special education."

Reference:

Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia. Effective July 1, 1990; amended August 1, 1991.

Related Services Words and Terms

The following words and terms are defined as they are used in "Related Services."

Audiology:

" 'Audiology' means

1. Identifying and evaluating children with hearing loss;
2. Determining the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the rehabilitation of hearing;
3. Selecting and fitting an appropriate aid and evaluating the effectiveness of amplification; and
4. Counseling and guidance of pupils and parents regarding hearing loss." (1)

Audiologist:

The following requirements are suggested as qualifications for an audiologist in an educational setting:

- The applicant should hold at least a master's degree in audiology or in speech pathology and audiology.
- The applicant should have completed academic work with a minimum of 60 semester hours which "demonstrates that the applicant has obtained a well-integrated program dealing with the normal aspects of human communication, development thereof, disorders thereof, and clinical techniques for evaluation and management of such disorders" (ASHA publication, 1973).

Reference:

American School Health Association publication, 1973.

Counseling Services:

" 'Counseling services' means services provided by qualified visiting teachers, social workers, psychologists, guidance counselors, or other qualified personnel." (1)

Deaf:

" 'Deaf' means hearing impairment which is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, which adversely affects educational performance." (1)

Medical Services:

" 'Medical services' means services provided by a licensed physician to determine a child's medically related handicapping condition which results in the child's need for special education and related services." (1)

Occupational Therapy:

" 'Occupational therapy' means services provided by a qualified occupational therapist or services provided under the direction or supervision of a qualified occupational therapist and includes:

1. Improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation;
2. Improving ability to perform tasks for independent functioning when functions are impaired or lost; and,
3. Preventing, through early intervention, initial or further impairment of loss of function." (1)

Occupational Therapist:

- Occupational therapy services are provided by a professional holding a bachelor's or master's degree in occupational therapy from an accredited school.
- The occupational therapist must hold current and valid certification by the State Board of Medicine of Virginia.
- This person is concerned with the facilitation, restoration and/or maintenance of optimum independence in handicapped students whose adaptive skills and/or effective functioning in the environment have been impaired.

- Occupational therapy utilizes a medically based, biopsychosocial orientation to evaluate the child's level of occupational performance skills in self-care tasks, play/leisure time tasks, and school/work tasks and the components needed to achieve these purposeful activities.

- Occupational therapists are trained to evaluate and provide treatment to improve performance in:

    - ○ Daily living skills - Physical skills (dressing, eating, moving, communicating, manipulating objects); emotional skills (maintaining a good self-concept, coping with people and events); and work skills (homemaking, employment).
    - ○ Sensorimotor skills - Neuromuscular components, sensory integrative components.
    - ○ Cognitive skills (orientation, conceptualization, problem solving).
    - ○ Psychosocial skills (self management, interaction between individuals and groups).
    - ○ Therapeutic adaptation (splints, prosthetics, assistive/adaptive equipment).
    - ○ Prevention (energy conservation, joint protection, positioning).

- Please see the following subsection, "Physical Therapist," for additional information.

Parent Counseling and Training:

" 'Parent counseling and training' means assisting parents in understanding the special needs of their child and providing parents with information about child development." (1)

Physical Education:

" 'Physical Education' means as follows:

1. The term means the development of:

    a. Physical and motor fitness;

    b. Fundamental motor skills and patterns; and,

c. Skills in aquatics, dance, and individual and group games and sports (including intramural and lifetime sports).

2. The term includes special physical education, adapted physical education, movement education, and motor development." (1)

Physical Therapy:

" 'Physical therapy' means services provided by a qualified physical therapist or under the direction or supervision of a qualified physical therapist upon medical referral and direction; and, includes the evaluation, testing, treatment, reeducation and rehabilitation by physical, mechanical, or electronic measures and procedures of individuals who because of trauma, disease or birth defects present physical and/or emotional disorders." (1)

Physical Therapist:

Physical therapy services are provided by a professional licensed as a physical therapist by the Virginia State Board of Medicine. This specialist is concerned with the prevention of disability and the maintenance and rehabilitation of individuals with physical handicapping conditions.

The purpose of physical therapy is to develop, restore, control, or maintain physical function through evaluation and treatment of acute and chronic disorders. Such conditions may include neurological, neuromuscular, musculoskeletal, peripheral-vascular, cardiopulmonary, and skin disorders.

In the educational setting, occupational therapy and physical therapy are related services in which the therapist functions as a member of an interdisciplinary team whose purpose is to provide an appropriate educational program for the handicapped student.

Both occupational and physical therapists perform functions in the following areas:

- General educational development
- Self-help or self-care
- Adaptation to individual needs and environmental circumstances
- Functional mobility
- Development of motor skills and strengthening of musculoskeletal systems.

Physical therapists' goals emphasize development of total body motor function, whereas occupational therapists emphasize skillful body functioning to accomplish tasks. For example, a physical therapist may work on trunk stability as it leads to sitting balance and standing balance, while an occupational therapist might work on trunk stability as it relates to shoulder stability to enhance fine-motor control.

Physical therapists are generally more skilled in treatment of respiratory and postural problems, evaluation of joint function, and individual muscle strength. Occupational therapists are generally more skilled in increasing muscle use for goal-directed activity, in treatment of sensory integration problems, and in treatment of feeding problems.

Psychological Services:

" 'Psychological Services' means:

1. Administering psychological and educational tests and other assessment procedures;
2. Interpreting assessment results;
3. Obtaining, integrating, and interpreting information about child behavior and conditions relating to learning;
4. Consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interviews, and behavioral evaluations; and
5. Planning and managing a program of psychological services, including psychological counseling for children and parents." (1)

Recreation:

" 'Recreation' means

1. Assessment of leisure function;
2. Therapeutic recreation services;
3. Recreation program in schools and community agencies; and

4. Leisure education." (1)

School Health Services:

" 'School Health Services' means services provided by a qualified school nurse or other qualified person." (1)

School Nurse:

- "A primary role of the school nurse is to manage school health services in the educational setting. Management involves using all available resources to accomplish the goals of programs by planning, organizing, implementing, and evaluating that program."

  Reference:

  American School Health Association. Implementation Guide for the Standards of School Nursing Practice. Kent, Oh: the Association, 1991.

- The staff school nurse must have a current license to practice as a registered professional nurse in the Commonwealth of Virginia. Please see Section I. Administrative Aspects of School Health for further information.

Social Services:

" 'Social Services' (Visiting Teacher/School Social Worker) means:

1. Collecting and integrating data to prepare a sociocultural assessment on a child referred for or identified with a handicapping condition;
2. Interpreting the sociocultural assessment;
3. Group and individual counseling with the child and family.
4. Working with those problems in a child's living situation (home, school, and community) that affect the child's adjustment in school;
5. Mobilizing school and community resources to enable the child to receive maximum benefit from his educational program; and

6. Offering consultation to school personnel and parents." (1)

Social Worker/Visiting Teacher:

- A social worker must have a master's degree in social work and current Virginia certification in social work.
- A visiting teacher must have a master's degree in education and current Virginia certification as a visiting teacher.

Speech or Language Impaired:

" 'Speech or Language Impaired' means a communication disorder, such as stuttering, impaired articulation, a language impairment, or a voice impairment, which adversely affects a child's educational performance." (1)

Speech and Language Pathology:

" 'Speech/Language pathology' includes:

1. Identification of children with speech or language disorders;
2. Diagnosis and appraisal of specific speech or language disorders;
3. Referral for medical or other professional attention necessary for the habilitation of speech or language disorders;
4. Provisions of speech and language services for the habilitation or prevention of communicative disorders; and
5. Counseling and guidance of parents, children, and teachers regarding speech and language disorders." (1)

Speech and Language Pathologist:

- Speech-language pathology is a licensed profession in the Commonwealth of Virginia.

- Speech-language pathologists who choose to practice in a setting other than Virginia public schools (even on a part-time basis) must be licensed. (Code of Virginia, Title 54.1, Chapter 26 Audiology and Speech Pathology).

- Licensure does not directly affect speech-language pathologists in the public schools since they are certified and endorsed by the Virginia Department of Education and, therefore, can provide services in the public schools.

- State endorsed speech-language pathologists, however, are not exempt from possession of a current license if they provide services on a private basis. The LEA should be aware of the licensure law and its implications.

Transportation:

" 'Transportation' means:

1. Travel to and from school and between schools;
2. Travel in and around school building; and
3. Specialized equipment (such as special or adapted buses, lifts, and ramps), if required to provide special transportation for a handicapped child." (1)

References

Note:

Above quotes referenced by the notation: "(1)" are from: Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia. Effective July 1, 1990; amended August 1, 1991. Virginia Department of Education, Division of Special Education Management and Programs.

Virginia's Special Education State Plan for Fiscal Years 1990-1992.

Guidelines for Occupational Therapy and Physical Therapy Services in the Public Schools of Virginia.

Virginia Board of Medicine, Regulations Relating to Medicare and Other Healing Arts, Occupational Therapy. UR465-08-01, January 1991.

Program Guidelines for Students with Speech-Language Impairment in Virginia Public Schools, 1991.

Program Guidelines for Audiological Services in Virginia Public Schools

ADAPTIVE PHYSICAL EDUCATION

Legal Basis

Adaptive physical education is currently identified as a related service under **P.L. 94-142** the **Education of all Handicapped Children Act**. Physical education services, specially designed if necessary, must be made available to every handicapped child receiving a free appropriate public education (Federal Register, 8/23/77, 121a. 307).

A student may also qualify for services under **P.L. 93-112 Section 504** of the **Rehabilitation Act of 1973** when a physical or mental impairment limits one or more major life activities.

Students who have temporary physical impairments (i.e., broken bones) may require adaptations in their physical education classes on a short term basis.

Recommendation

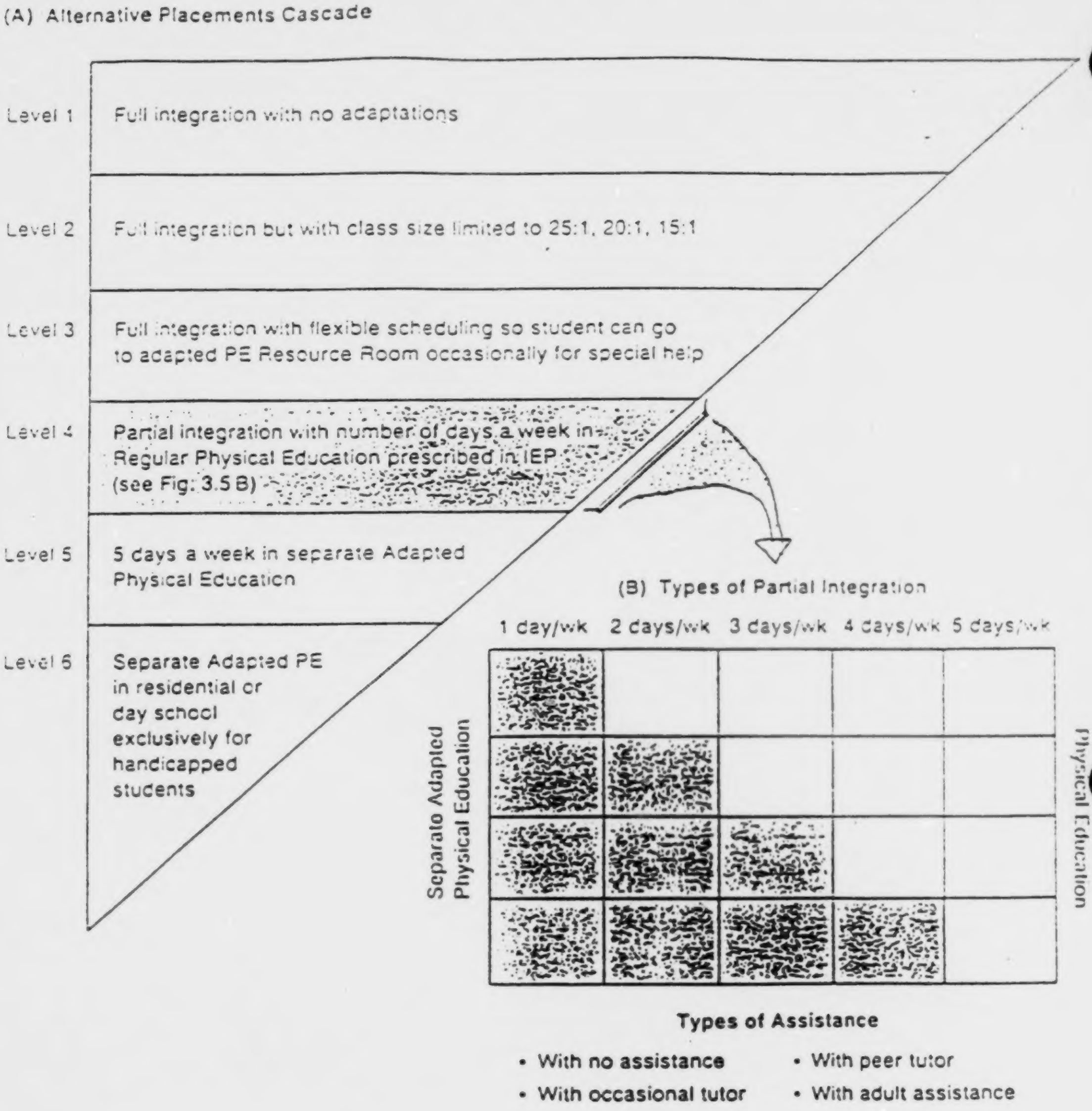
Physical Education Placements

The following describes alternative physical education placements in terms of restriction (see Figure 10).

Levels for Physical Education:

- Level 1: Full integration with no adaptations.
- Level 2: Full integration but with class size limited to 25:1, 20:1, 15:1.
- Level 3: Full integration with flexible scheduling so student can go to adapted physical education resource room occasionally for special help.
- Level 4: Partial integration with number of days a week in regular physical education prescribed in IEP; with the following types of assistance: no assistance, occasional tutor, peer tutor, adult assistance.
- Level 5: Five days a week in separate adapted physical education.
- Level 6: Separate adapted physical education in residential or day school exclusively for handicapped students.

Figure 10 (A) Alternative physical education placements cascading upward from most to least restrictive modeled after Deno's (1970) Cascade System of Special Education Service. (B) Types of partial integration and of assistance that should be prescribed on IEP for students in Level 4 of the Alternative Placements Cascade. Any of the types of assistance can be paired with any of the types of partial integration


(A) Alternative Placements Cascade
Level 1
Full integration with no adaptations
Level 2
Full integration but with class size limited to 25:1, 20:1, 15:1
Level 3
Full integration with flexible scheduling so student can go to adapted PE Resource Room occasionally for special help
Level 4
Partial integration with number of days a week in Regular Physical Education prescribed in IEP (see Fig. 3.5 B)
Level 5
5 days a week in separate Adapted Physical Education
Level 6
Separate Adapted PE in residential or day school exclusively for handicapped students
(B) Types of Partial Integration
1 day/wk
2 days/wk
3 days/wk
4 days/wk
5 days/wk
Separate Adapted Physical Education
Regular Physical Education
Types of Assistance
• With no assistance
• With peer tutor
• With occasional tutor
• With adult assistance

Resources

Equipment and Activity:

- Flaghouse, Inc. and Flaghouse Special Populations
  150 North MacQuesten Parkway
  Mount Vernon, NY 10550

  1-800-221-5185

  They offer a variety of balls, movement education equipment, large scooters, and mini-beepers.

- Front Row Experience
  540 Discovery Blvd.
  Byron, CA 94515

  1-415-634-5710

  They offer a variety of activity books and equipment such as Perceptual-Motor Lesson Plans Book 1 & 2, Successful Movement Challenges, Parachute Movement Games, wind wands, geometric shapes, coordination ladders, and launching boards.

- Science Products
  Box 888
  Southeastern, PA 19399

  1-800-888-7400

  They offer a variety of equipment for the visually impaired student such as beep footballs, beep soccer balls, beep softballs, bell balls, chargers, and sound sources.

- Sportime
  2905-E Amwiler Rd.
  Atlanta, GA 30360

  1-800-444-5700

  They offer a variety of balls, large scooters, basic movement skills equipment, Volleyball Trainers, and Slow-Mo Balls.

Bibliography:

- Bleck, Eugene E., M.D., and Donald A. Nagel, M.D. Physically Handicapped Children: A Medical Atlas for Teachers. Orlando, Fl.: Grune & Stratton, 1982.
- Sherrill, Claudine. Adapted Physical Education and Recreation. Dubuque, Ia.: William C. Brown Publishers, 1986.
- Physical Education Guide for Students with Handicapping Conditions. Virginia Department of Education, Division of Special Education Programs and Pupil Personnel Services and Division of Sciences and Elementary Administration, Revised 1986.

Forms

Please see the following sample forms at the end of this section:

- Adaptive Physical Education Program Parent/Guardian Letter
- Physician's Activity Limitation Form

SAMPLE

VIRGINIA BEACH CITY PUBLIC SCHOOLS

ADAPTED PHYSICAL EDUCATION PROGRAM

Dear Parent or Guardian:

The Virginia Beach City Public School System provides physical education for all students. Every student, unless restricted from all activity, participates in some form of physical exercise. Some students may need to be placed in an adapted physical education class due to a permanent or semi-permanent physical condition.

The attached Physician's Activity Limitation Form is used to provide the school with specific information concerning your child's disability. This form helps the physical education instructor plan a program of physical activity for your child.

Please have a physician complete the attached form and have your child return it to the school as soon as possible. The physician plays a vital role in the placement process by providing the diagnostic information used to determine an appropriate program of activities for your child.

Questions regarding your child's placement in the physical education program may be directed to the school nurse or guidance counselor.

Sincerely,

____
SCHOOL DESIGNEE

____
SCHOOL

____
PHONE

____
DATE

BEST COPY AVAILABLE

VIRGINIA BEACH CITY PUBLIC SCHOOLS
Physician's Activity Limitation Form

SAMPLE

The Virginia Beach City Public School System provides physical education for all students. Every student, unless restricted from all activity, participates in some form of physical exercise. Some students may need to be placed in an adapted physical education class, due to a permanent or semi-permanent condition.

The physician plays a vital role in the placement process by providing the diagnostic information used to determine an appropriate program of activities for the student. Please use this form to provide the school with information concerning the student's specific disability.

Your assistance and cooperation are greatly appreciated.

Student's Name______________________________ School____________________

Brief Description of Condition____

____

This is a________permanent ________temporary condition.

Check the situations that WILL NOT BE appropriate for this student's condition.

______ Cardiac Stress
______ Sun Exposure
______ Pressure on the atianto-axial joint
______ Activities that may involve contact
______ Activities that increase bladder or bowel stress

Check the categories that WILL NOT BE appropriate for this student, even with adaptations and modifications.

______ Abdominal Endurance
______ Agility skills
______ Balance activities
______ Bouncing exercises
______ Catching motion
______ Isometric exercises
______ Isotonic exercises
______ Kicking motion
______ Lower body strengthening
______ Sprinting
______ Stretching exercises
______ Striking motion
______ Throwing motion
______ Upper body strengthening
______ Weight-bearing activities

Indicate the number of minutes of maximal cardiovascular workout and the speed of movement at which the student may be expected to safely participate.

NUMBER OF MINUTES

______ milo duration (1-5 min.)
______ minimal duration (6-10 min.)
______ moderate duration (11-15 min.)
______ maximum duration (over 16 min.)

SPEED OF MOVEMENT

______ walk
______ jog
______ run

I request that the school nurse contact me upon receipt of this form.
______ YES ______NO Physician's telephone__________

These recommendations for this student's physical activity are for a period of ______ weeks/months.

Physician's Signature______________________________M.D. Date____________

Parent/Guardian's Signature__________________________ Date____________

Please use the back of this form to include any other important data or comments.

DEVELOPMENTAL DELAY

Legal Basis

Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia, Effective July 1, 1990; Amended August 1, 1991.

Developmental Delay Criteria

Preschool children with disabilities below age 5 may be determined as eligible for services through the identification of a "developmental delay", a term which means a child exhibits a significant delay in one or more of the following areas of development: cognitive ability, motor skills, social/adaptive behavior, perceptual skills, and communication skills. Delays cannot be considered as isolated factors and must not be separated from the total developmental progress of the child. The importance of a delay may vary from child to child depending on numerous factors: e.g., age, experiences, multicultural background, area of delay, range and severity of delay, and comparison of delay with other skill areas.

Definitions:

" 'Developmentally Delayed' means a child below age eight who exhibits a significant delay in one or more of the following areas of development:

1. Cognitive ability
2. Motor skills
3. Social/adaptive behavior
4. Perceptual skills
5. Communication skills"

" 'Handicapped children' means those children evaluated, in accordance with these regulations, as being mentally retarded, hard of hearing, deaf, speech or language impaired, autistic, visually impaired, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf-

- Autistic
- Severely and profoundly handicapped

Definitions of these identifiers can be found in the Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia. However, it should be noted that state and federal definitions of disabilities are written in terms of their effects on educational performance. Since this standard does not readily apply to preschoolers, it is more useful to consider how these conditions affect "developmental functioning." That is, the disability adversely affects development of functions rather than educational performance.

Problems of Speech and Language

Children may exhibit problems in the area of speech (articulation), voice or language. A child who is determined to be speech and language impaired has a communication disorder. This may be in the area of articulation, stuttering, language, or voice. This impairment adversely affects the child's educational performance.

Evaluation components needed for making this determination include:

- A speech and language evaluation completed by a speech-language pathologist.
- An audiological assessment if the child has failed two hearing screening tests completed by an audiologist.
- Other reports as deemed appropriate.

For preschool children suspected of having a speech/language impairment, minimum requirements for determining eligibility include: speech and language evaluation, hearing screening, developmental and other reports as required. For those preschool children whose speech/language assessment reveals language impairment, a comprehensive evaluation is required which includes medical, sociocultural, developmental, and psychological components.

Reference:

Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia, Virginia regulations, revised, 1990, 3.3, Subsection G.

Problems of Social/Emotional Development

Children may exhibit behavior that is not readily measurable on developmental scales. In such instances, data collection -- such as documentation of frequency and type of inappropriate behavior -- in addition to clinical observations may be necessary to determine the significance of a delay.

Qualifying Factors

Test scores or other measures of delay must be considered in light of additional factors which may influence the interpretation of scores, child performance, or behavior.

Examples of such factors include:

- High Risk

  History of medical problems; and, experiential and/or nutritional deprivation.

- Social/Adaptive

  Socially unacceptable behavior; behavior which inhibits development, increases distractibility, shortens attention span; inappropriate/interpersonal relationships with peers and adults.

- Communication

  Inability to follow directions; frustration with communicating efforts; low level of intelligibility; overuse of gestural language in place of verbal communication; overriding dialectical influences; word retrieval problems; evidence of echolalia; poor oral motor functioning; fluctuating hearing problems.

Reference:

Guidebook for Early Childhood Special Education Programs in Virginia's Public Schools. Virginia Department of Education, Division of Special Education Programs and Pupil Personnel Services, June 1985.

CHILD FIND

Legal Basis

Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia. Effective July 1, 1990; Amended August 1, 1991.

Responsibilities of Local School Divisions and State Agencies

Child Find:

"Child Find

1. Each local school division shall, at least annually, conduct a public awareness campaign to:
    a. Inform the community of a person's statutory right to a free appropriate education and the availability of special education programs and services;
    b. Generate referrals; and,
    c. Explain the nature of conditions, the early warning signs of conditions, and the need for early intervention.
2. Procedures for informing the community shall show evidence of the use of a variety of materials and media, and shall:
    a. Provide for personal contacts with community groups, public and private agencies and organizations; and
    b. Provide information in the person's native language or primary mode of communication.
3. There shall be evidence of involvement of parents and community members, as well as the local special education advisory committee, in the required child find and community awareness campaign.
4. Each local school division shall maintain an active and continuing child find program designed to identify, locate and evaluate those children from birth to 21, inclusive, who

are in need of special education and related services. Written procedures shall be established for collecting, reviewing and maintaining such data.

5. All children ages two to 21, inclusive, not enrolled in school and who are suspected of having a handicapping condition shall be referred to the division superintendent, or designee, who shall initiate the process of determining eligibility for special education services.

6. Where such children are determined to be eligible for special education services, school divisions are required to offer appropriate programs and placements consistent with each child's IEP from ages two to 21 inclusive." (1)

Reference

(1) Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia. Effective July 1, 1990; Amended August 1, 1991.

SECTION 504 OF THE REHABILITATION ACT OF 1973

Legal Basis

Public Law 93-112, Section 504 of the Rehabilitation Act of 1973.

Excerpt:

"No otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Definitions

Section 504:

" 'Section 504' means that section of the Rehabilitation Act of 1973 which is designed to eliminate discrimination on the basis of handicap in any program or activity receiving federal financial assistance."

Reference:

Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia, Effective July 1, 1990; Amended August 1, 1991.

Qualified Person:

The definition of a qualified person under Section 504 covers a broader population than the definition of a handicapped person under P.L. 94-142 (now P.L. 101-476). A "qualified handicapped individual" under 504 is any person who: (1) has a physical or mental impairment which substantially limits one or more major life activities; (2) has a record of such an impairment; and (3) is regarded as having such an impairment.

Physical or Mental Impairment:

Specifically, a "Physical or mental impairment" can be (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory including speech organs, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine, or (b) any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning abilities.

Major Life Activities:

"Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

Record of Impairment:

"Has a record of such an impairment" means has a history of, or has been classified as having a mental or physical impairment that substantially limits one or more major life activities.

Having an Impairment:

"Is regarded as having an impairment means (a) has a physical or mental impairment that does not substantially limit major life activities, but is treated by a recipient as constituting such limitation; (b) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or (c) has none of the impairments defined in section one, but is treated by a recipient as having such an impairment."

Recommendation

Process

The School Nurse's Role in the 504 Process:

Each local division must have policies and procedures implementing the 504 process. The school nurse must be familiar with the process and know these steps.

Referral:

The first step of the process is referral. Students falling under the auspices of P.L. 94-142 (now P.L. 101-476) or Section 504 generally are those who meet one or more of the following descriptions:

- Are experiencing academic difficulty (below grade level performance) and it is suspected that the medical condition is or will adversely affect classroom functioning.
- Need medically related adaptations to perform in a regular education classroom placement.
- Need or may need homebound instruction made available on an intermittent basis due to medical condition.

The building principal is generally the central figure in any process involving special services for students assigned to the school. It is the responsibility of all staff (secretaries, teachers, visiting teachers, health professionals, psychologists, and other support personnel) to immediately make the principal aware of any student who has been identified as needing specific health related care. Parents may also refer their children or request services.

Every effort should be made to review health information on all students when they enroll. The school nurse may assist the 504 coordinator of the local division by notifying the principal of qualified handicapped persons who are not receiving an appropriate public education.

Each qualified handicapped person must be educated with persons who are not handicapped to the maximum extent appropriate to the needs of the handicapped person. Thus, the handicapped child is placed in the regular educational environment unless it is demonstrated that the child cannot be educated there, even with the use of supplementary aids and services.

Screening:

The school division may elect to have either a centralized committee or a school based building screening committee. The committee may consist of principal/designee, the student's regular education teacher(s), specialist(s), school nurse, nurse practitioner, public health nurse, parents and/or referring source, and any other persons deemed necessary.

As a member of this committee the school nurse may assist in determining whether a complete comprehensive assessment and/or any single or multiple assessment is necessary in order to make a determination of the child's needs. The nurse may recommend that the screening committee request additional information, reports or records, classroom observation or intervention.

The 504 evaluation may consist of the following written components:

- Medical
- Psychological
- Educational
- Socio-cultural
- Others as appropriate to the student's suspected handicap; i.e., an audiological may be requested to determine a student's eligibility for hearing impairment services.

Evaluation:

Rule: Evaluation should be performed for anyone who, because of a handicap(s), is suspected of needing special education and related services. The evaluation must be made prior to initial placement and prior to any significant change in placement. Procedures should be developed for this evaluation that ensure the following:

- Evaluation materials are appropriate for intended use.
- Evaluators are properly trained.
- Evaluation materials used should test relevant areas of educational need and not merely IQ.
- Where possible, selection and administration of tests should accommodate sensory, manual, and speaking deficiencies.

Eligibility:

The 504 eligibility committee may consist of the following individuals: director of special services, school psychologist, school social worker, school nurse, educational diagnostician, representative from the referring school, student, family member and individuals representing the assessment components as required. Each division will determine the membership based on local needs.

If the evaluation and placement provisions of the regulation are fully applicable, § 104.35 (c) (3) requires that placement decisions be made by a group of persons, including persons knowledgeable about the child, the meaning of evaluation data, and the placement options. The school nurse is the medical expert on site and should be a member of the 504 eligibility committee to interpret medical data.

The purpose of the eligibility meeting is to determine whether or not there is a handicapping condition, as defined under Section 504, that causes the student to be excluded from participation in, or be denied the benefits of, the educational program.

The Section 504 Evaluation Committee is responsible for determining the following:

- Whether the student is handicapped
- The type of handicap
- The effect of any handicap on the student in the school setting.

The 504 Plan:

A Section 504 Educational Plan shall be developed to incorporate the services that the student needs in the educational setting. If there are educational implications, accommodations must be made.

Development of the plan should be made within 30 days of identification. The school nurse may assist in developing the components of the 504 Plan that deal with health issues.

Please see the following sample health plans with individualized requirements at the end of this section:

- Individual Health Care Plan (Aurora Public Schools, Colorado)
- Section 504 Plan (Virginia Beach City Public Schools)
- Sample 504 Plan Requirements: Example

SAMPLE

Aurora Public Schools
Department of Special Education
Lansing Annex 11023 East Fifth Avenue
Aurora, Colorado 80010

INDIVIDUAL HEALTH CARE PLAN FOR (Student's Name)

STUDENT ____________________ BIRTHDATE ____________________
SCHOOL ____________________ GRADE/PROGRAM ____________________
DATE ____________________ PARENT ____________________
EFFECTIVE ____________________ PARENT ____________________
COMPRECARE TEL NO ____________________ HOME PHONE ____________________
GROUP # ____________________ WORK PHONE (mother) ____________________
(father) ____________________

PHYSICIANS
1 Dr A - Pediatrician telephone number
2 Dr B - Neurologist, Children's Hospital, telephone number
3 University of Colorado Health Sciences Center, Cardiology Department C R N

EMERGENCY CONTACT PERSON IF BOTH PARENTS ARE UNAVAILABLE

PROBLEM #1 - Seizures

W has grand mal focal and petit mal seizures. His seizures began at 18 days and occur frequently and sporadically although primarily in the early morning. He is followed by Dr. B at Children's Hospital. He currently takes Depakane, 1500 mgm a day and Tegretal 700 mgm a day. All medications are taken at home.

SPECIFIC PRECAUTIONS

1 Prior to a grand mal seizure, he frequently complains of nausea.
2 If he complains of nausea or begins to display signs of a grand mal seizure
  STAY WITH HIM DURING SEIZURE.
  a Ease him to the floor onto his abdomen and away from hard or sharp objects
  b Make certain that his airway is open by turning his head to the side
  c Do not put anything in his mouth
  d If the seizing activity lasts more than 10 minutes, call 911
  e After calling 911, call Dr. A's office. Give Comprecare numbers, group number. Request instructions regarding which hospital he is to be transported to
  f Tell paramedics that he has a pacemaker implanted
  g Have someone call his mother
  h If seizure lasts less than 10 minutes, allow to rest in health office and call mother
  i Note on health record, length of time of the seizure, and any unusual events occurring prior to or during the seizure
3 Focal Motor - W's symptoms of a focal motor seizure consist of spastic movement of the left arm and lack of awareness of his surroundings. These symptoms may last up to 4 or 5 minutes. After the movement ceases, he will complain of headache and possible nausea
  a Allow to rest in the clinic, he may fall asleep. Observe closely
  b Call mother
  c When he becomes alert and oriented, if he complains of headache, give him Tylenol per mother's written instructions
  d Do not allow playing on high equipment in P E or on playground
4 Petit Mal Seizure - W's symptom consists of a simple staring spell which usually lasts less than a minute. No special first aid treatment is needed.

PROBLEM #2 - Pacemaker Implant

W had open heart surgery at one day of age, due to transposition of the great vessels. He had subsequent surgeries at age 2 and age 7 to implant a pacemaker. He will have monthly pacemaker checks via the telephone for a tele-track transmission with C.R.N., Cardiology Department, University of Colorado Health Sciences Center, hospital telephone. The apparatus needed for the check will be kept in the school health office. W's pacemaker is located below the sternum and directly above the navel and is implanted under the skin.

SPECIFIC PRECAUTIONS

1. No jumping from high places or distance or on trampolines.
2. No hard blows to the abdomen.
3. No contact sports.
4. If complains of chest pain or dizziness, contact Pediatric Cardiology Unit, telephone number.
5. If he falls asleep in class, pallor, or increased fatigue are noted, notify mother.
6. He must avoid contact with magnets or radio or television antennas whch could emit radio waves as they will cause his pacemaker to malfunction. He may be around microwave ovens.

PROBLEM #3 - History of Strokes

W has had two known strokes both affecting his left side. The first one occurred at 3 days of age. The second at 15 to 20 months of age. Both were thought to be due to side effects of his open heart surgery. The residual effects are left sided weakness. He has received extensive physical therapy and occupational therapy relative to the weakness.

PROBLEM #4 - Socio-emotional Concerns

W is apparently very self-conscious and concerned about his seizure activity. He is apprehensive about having a seizure in the classroom or on a field trip.

SPECIFIC PRECAUTIONS:

1. Reassure W that all of the school staff that he will be in contact with, both at school and on field trips, are aware of the first aid measures needed in the event of a seizure.
2. W's classmates should receive instruction about seizures in order to increase their understanding and acceptance.

Signature of nurse preparing report ____________________
Parent ____________________ Physician ____________________

BEST COPY AVAILABLE

VIRGINIA BEACH CITY PUBLIC SCHOOLS
SECTION 504 PLAN

CASE: ______________ ADDRESS: ______________ SCHOOL: ______________

DOB: ______________ PHONE: ______________ ANNUAL REVIEW DATE: ______________

A. The conference was conducted to develop the Section 504 Plan on: ______________
Date

B. List the name of each person and his/her position or relationship who participated in the development of the Section 504 Plan and who were present at the conference.

Name	Position

C. Plan Requirements:

____

____

____

____

____

____

____

D. I _____ do _____ do not give consent for my child ______________, to receive the service described in the Section 504 Plan. Unless this is an initial plan, I understand that if I do not disapprove this plan and so notify the school division within ten administrative days, the Section 504 Plan will be implemented as if consent has been granted and that I must initiate due process to contest the action. I understand the contents of this document and I have been informed of my Section 504 due process rights. I understand that I have the right to review my child's records and to request a change in the Section 504 Plan at anytime. I also understand that I have the right to refuse this plan and to have my child continue in his/her present placement pending exhaustion of due process procedures. I have received a copy of the Section 504 Plan.

E. Reason (s) for Disapproval (If applicable)

____

____

____

____

F. ___/ ___/ ___/ ______________
Month Day Year Signature(s) of Parent(s)/ Guardian(s)/Surrogate/ Student (If applicable)

SAMPLE

WHITE - SCHOOL CANARY - SPECIAL EDUCATION PINK - PARENT (S)/GUARDIAN(S)/SURROGATE

Sample 504 Plan Requirements

Plan Requirements for a Child With Cystic Fibrosis:

1. Molly will take creon enzyme capsules with each meal and snack on her own (to be kept by her).
2. Mother will notify us when Molly is taking antibiotics and she will follow School Board Policy 7-57 if administered during school hours.
3. The P.E. teacher will be notified that Molly loses 5-6 times the amount of salt as someone without cystic fibrosis so precautions should be taken to avoid her becoming overheated.
4. A notation shall be made in the P.E. teacher and regular classroom teacher lesson plans so substitutes are aware of these issues.
5. Have Molly gauge activity tolerance in P.E. and allow to rest when fatigued.
6. If Molly coughs up bright red blood, has difficulty breathing or complains of extreme fatigue, contact ________________________ (check with parent).

SECTION 504 ELIGIBILITY: SPECIFIC HANDICAPS

Legal Basis

Public Law 93-112, the *Rehabilitation Act of 1973*, Section 504.

Recommendation

The key to reviewing this issue is that *individual* decisions need to be made relative to the student's *particular* *needs*.

Conditions That Were Found To Be Handicaps in Individual Cases

AIDS:

Students with AIDS and AIDS related complex (ARC) and students who are asymptomatic carriers of the AIDS virus (HIV) are eligible under Section 504. It is generally assumed by the courts that having AIDS automatically limits a major life activity. OCR Staff Memorandum, 16 EHLR 712 (1990); *Thomas v. Atascerdo Unified School District, et al.*, 662 F. Supp. 376 (C.D. Cal. 1987); *Ray v. School District of DeSoto County*, 666 F. Supp. 1524 (M.D. Fla. 1987); *Doe v. Dolton Elementary School District No. 148*, 694 F. Supp. 440 (N.D. Ill. 1988); Chalk v. U.S. District Court, 840. F. 2d 701 (9th Cir. 1988).

Alcohol/Drug Dependency:

- A drug addict or recovering drug addict is defined as handicapped under Section 504. In the particular case, the student was not a "qualified handicapped person" because he or she was unable to benefit from the vocational education program from which he was excluded. "Section 504 does not compel education institutions to disregard a disability; rather, Section 504 holds only that the mere possession of a handicap is not a permissible ground for assuming the individual will be unable to function in a particular context." *Northwest Kansas Area Vocational-Technical School*, 3 EHLR 353:190 (OCR 1989).
- "Alcoholism and drug addiction are included as physical impairments which fall under the coverage of Section 504 and are not covered under EHA." *Des Jardins*, EHLR 213:144 (OSEP 1988).

- Alcoholism and drug addiction are included in the definition of handicapped. Wallace v. Veterans Administration, 683 F. Supp. 758 (D. Kan. 1988).

Allergies:

Allergies to smoke and to general environmental conditions are Section 504 handicaps. Middlebury (IN) Community Schools, EHLR 257:593 (OCR 1984); Greensville County (VA) School Board, EHLR 353:118 (OCR 1988).

Asthma:

Having a breathing impairment which limits the ability to participate fully in the educational process qualifies a student as handicapped under Section 504. Yorktown (NY) Central School District, 16 EHLR 108 (OCR 1990).

Attention Deficit Hyperactivity Disorder (ADHD):

- Student with Attention Deficit Disorder (ADD) was not a Section 504 qualified handicapped person because his ADD did not substantially limit his ability to learn. Jefferson Parish (LA) Public Schools, 16 EHLR 755 (OCR 1990).

- Hyperactive student was potentially a qualified handicapped person as defined by 34 C.F.R. Section 104.3(k)(2). Because the School Board had not yet evaluated him to determine whether he was handicapped, OCR could not establish that the child was discriminated against or punished because of a handicap. Jefferson County (CO) School District R-l, 16 EHLR 520 (OCR 1989).

- Student was a Section 504 qualified handicapped person and required related services because ADHD limited his ability to learn and to benefit from other parts of the educational program. Fairfield-Suisun (CA) Unified School District, 3 EHLR 353:205 (OCR 1989).

- School Board violated Section 504 by denying, an ADHD student the special educational services he needed and by improperly punishing him on the basis of his handicap. LEA failed to evaluate and place him because of ignorance of the Section 504 definition of "handicapped." Rialto (CA) Unified School District, 3 EHLR 353:201 (OCR 1989).

Blindness:

Blindness is a Section 504 handicap. Norcross v. Sneed, 755 F.2d 113 (8th Cir. 1985).

Congenital Defects:

- A high school football player with only one kidney was eligible under Section 504. Grube v. Bethlehem Area School District, 550 F. Supp. 418 (E.D. PA. 1982).
- A student with congenital limb deficiency was handicapped within the meaning of Section 504. Wolff v. South Colonie Central School District, 534 F. Supp. 758 (N.D. N.Y. 1982).
- High school student with one kidney was handicapped under Section 504, but allowed to wrestle on his school's wrestling team. The court held, "Life has risks. The purpose of Section 504, however, is to permit handicapped individuals to live life as fully as they are able, without paternalistic authorities deciding that certain activities are too risky for them." Poole v. South Plainfield Board of Education, 490 F. Supp. 948 (D.N.J. 1980). 490 F. Supp. at 953-54.
- An infant with a congenital defect is handicapped under Section 504. Bowen v. American Hospital, et al., 476 U.S. 610 (1986).
- School children with one eye were eligible under Section 504. Kampmeier v. Nyguist, 553 F.2d 296 (2nd Cir. 1977).

Deafness:

The condition of being deaf constitutes a Section 504 handicap. Southeastern Community College v. Davis, 447 U.S. 397 (1978).

Deaf Parents:

Deaf parents of students are entitled to interpreter services for school conferences and similar events. Rothschild v. Grottentholer, 16 EHLR 78 (S.D.N.Y. 1989). Ramapo (NY) Central School District, 16 EHLR 559 (OCR 1989). OCR Staff Memorandum, 16 EHLR 542 (OCR 1989).

Diabetes:

School Board refused services (glucose testing and diet assistance) to a diabetic student because she did not need special education. OCR found that ". . . a student whose educational needs can be met within the regular education environment may nevertheless be determined to be handicapped. In such instances, the appropriate program would consist of regular education and the related services that are determined to be needed." Bement (IL) Community Unit School District #5, 3 EHLR 353:383 (OCR 1989).

Dwarfism:

"By medical definition, dwarfism is a physical impairment. It is a physiological condition which affects the musculoskeletal system....If dwarfism also has the effect of substantially limiting one or more of a person's major life activities, or if the condition is so regarded by a recipient, such a person would be considered handicapped within the meaning of Section 504." Anonymous, 3 EHLR 305:21 (OCR 1984).

Epilepsy:

- "Student with epilepsy and mental retardation was handicapped and could not be excluded from swimming class unreasonably. Because the decision rested on individual medical information as to type and frequency of seizures, the exclusion did not violate Section 504." New Rochelle (NY) City School District, 3 EHLR 353:354 (OCR 1989).
- Policy of refusing to recognize epilepsy per se as a handicapping condition does not violate Section 504 handicap. Epilepsy may, however, be a Section 504 handicap. Akers v. Bolton, 531 F. Supp. 300 (D. Kan. 1981).

The Formerly Handicapped:

Those individuals formerly identified as handicapped are entitled to Section 504 protection. San Francisco (CA) Unified School District, 3 EHLR 353:227 (OCR 1989).

Hepatitis B:

- Hepatitis B is a Section 504 handicap. The School Board violated Section 504 when it excluded student who was a hepatitis B carrier when there was not a medical basis for the exclusion. Clare-Gladwin (MI) Intermediate School District, 16 EHLR 105 (OCR 1989).

- Hepatitis B carrier and TMR student is handicapped and cannot be excluded from school solely out of fear of his hepatitis. Jeffrey S. v. Georgia State Board of Education, 4 EHLR 441:576 (S.D. Ga. 1989).

Hemophilia:

The student with hemophilia who is school age is a qualified handicapped person. School District of Pittsburgh (PA), EHLR 257:492 (1984).

Obesity:

Obesity is a condition which has been medically recognized and can lead to substantial impairments of major life activities. The inquiry can turn on the perception of others that the individual in question has a physical impairment that substantially limits a major life activity. Such perceptions bring the individual within the regulatory definition of a handicapped person.

OCR Staff Memorandum, 3 EHLR 307:17 (OCR 1989). Like other Section 504 handicaps, obesity must receive a case-by-case individualized determination.

Pregnancy:

- A fifteen-year old high school student was handicapped due to her hospitalization for medical problems related to her pregnancy. The student was a Section 504 qualified handicapped person due to her medical problems. Blount County (TN) School District, 16 EHLR 504 (OCR 1989).
- Pregnancy is not *per se* a handicap under Section 504. Rochester NY School District, 3 EHLR 311:09 (OCR 1980).

Schizophrenia:

This condition has been determined to be a Section 504 handicap. Franklin v. U.S. Postal Service, 687 F. Supp. 1214 (S.D. Ohio 1988).

Retinitis Pigmentosa:

Doherty v. Southern College of Optometry, 862 F.2d 570 (6th Cir. 1988).

Social Maladjustment:

Students who are socially maladjusted should be considered for identification as handicapped. Irvine (CA) Unified School District, 3 EHLR 353:192 (OCR 1989).

Temporary Conditions:

- Student who was temporarily handicapped as a result of an automobile accident was covered by Section 504 and entitled to full complement of homebound courses. Lee's Summit (MO) R-VII School District, EHLR 257:629 (OCR 1984).
- Students who use crutches may be handicapped under Section 504. School District of Pittsburgh, Pa., EHLR 257:492 (OCR 1984).

Tourette's Syndrome:

Tourette's Syndrome is a Section 504 handicap. School district denied student free appropriate public education and due process rights when principal unilaterally dropped him from the rolls of a high school without attempting to establish whether his academic deterioration was related to his Tourette's Syndrome. Fontana (CA) Unified School District, 3 EHLR 353:248 (OCR 1989).

Tuberculosis:

Individual who had been hospitalized for tuberculosis and tests positive in cultures is a handicapped individual who cannot be excluded from teaching unless it is established that her continued presence posts significant health and safety risks. School Board of Nassau County v. Arline, 480 U.S. 273 (1987).

Conditions Which Do Not Give Rise to Section 504 Eligibility

Cerebral Palsy:

Individual with a barely detectable case of cerebral palsy is not handicapped. Pridemore v. Legal Aid Society of Dayton, 625 F. Supp. 1171 (S.D. Ohio 1985).

Disruptive Students:

Students who are simply disruptive but not educationally impaired are not handicapped under Section 504. Shasta County (CA) Office of Education, 3 EHLR 353:196 (OCR 1989).

Left-Handedness:

Being left-handed is not a condition which qualifies as a handicap. de la Torres v. Bolger, et al., 781 F.2d 1134 (5th Cir. 1986).

Need for Psychiatric Services:

Congress could not have intended Section 504, a broad brush statute enacted to prohibit discrimination against the handicapped, to impose a greater duty on states to provide educational services to the handicapped than the EHA, which specifically addresses special education and details the educational services states must provide to receive federal funds, a state policy barring the provision of psychiatric services in connection with provision of Free Appropriate Public Education is not in violation of Section 504. Darlene L. v. Illinois State Board of Education, et al., EHLR 554:532 (N.D. Ill. 1983).

Poor Judgment, Irresponsible Behavior, and Poor Impulse Control:

..."[P]oor judgment, irresponsible behavior, and poor impulse control do not amount to a mental condition that Congress intended to be considered an impairment which substantially limits a major life activity and, therefore, a person having those traits or perceived as having those traits cannot be considered a handicapped person within the meaning of the Act." An applicant who exhibited these characteristics and thus was not hired by the police department, was not discriminated against under Section 504. Daley v. Koch, 892 F.2d 212, 215 (2nd Cir. 1989).

Sleep Apnea:

Mere allegation of the existence of a handicap will not establish a handicap. Sleep apnea will not be considered as a handicap if it is not supported by medical evidence and did not cause the tardies [(late arrival to work)]. Merrilville (TN) Community School Corporation, 3 EHLR 352:151 (OCR 1985).

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CODE OF VIRGINIA:

SECTIONS RELATING TO SCHOOL HEALTH

INTRODUCTION

Summary

There are Virginia laws and regulations pertaining to school health services that should be considered in planning and administering a school health services program.

These laws and regulations include, but are not limited to the following (the number after each title refers to the Code of Virginia, section number):

Attendance Requirements:

a. Ages of children required to attend. (22.1-254)

b. Preschool physical examination. (22.1-270)

c. Immunization requirements. (22.1-271.2)

d. Immunization of children against certain diseases. (32.1-46)

e. Exclusion from school of children not immunized. (32.1-47)

f. Birth certificates required upon admission. (22.1-3.1)

Contagious Diseases:

g. Contagious and infectious diseases. (22.1-272)

h. Confidentiality of test for human immunodeficiency virus; civil penalty; individual action for damages or penalty. (32.1-36.1)

i. Guidelines for school attendance for children infected with human immunodeficiency virus. (22.1-271.3)

j. Immunity from liability. (32.1-38)

k. Reports by persons other than physicians. (32.1-37)

l. Surveillance and Investigation. (32.1-39)

m. Tuberculosis certificate. (22.1-300)

Child Abuse and Neglect:

n. Definitions. (63.1-248.2)

o. Physicians, nurses, teachers, etc. to report certain injuries to children; penalty for failure to report. (63.1-248.3)

p. Immunity of person making report, etc., from liability. (63.1-248.5)

q. Authority to talk to child or sibling. (63.1-248.10)

r. Cooperation by state entities. (63.1-248.17)

School Health Personnel:

s. School health services (22.1-274); this references standard 2 - support services (22.1-253.13:2).

Vision and Hearing Screening:

t. Sight and hearing of pupil to be tested (22.1-273).

Advisory Board:

u. School health advisory board (22.1-275.1).

Health Care for Minors/Emergency Care:

v. Authority to consent to surgical and medical treatment of certain minors (54.1-2969).

w. Health Care for Minors/Emergency Care: Persons rendering emergency care, obstetrical services, exempt from liability (8.01-225).

Safety and Clean Air:

x. Protective eye devices (22.1-275).

y. Criteria to identify toxic art materials; labeling use in certain grades prohibited (22.1-274.1).

z. Indoor clean air act (15.1-291.1).

Special Education:

aa. Definitions (22.1-213).

bb. Board to prepare special education program for handicapped children (22.1-214).

cc. Visually impaired children (22.1-217).

dd. Transportation of handicapped children attending public or private special education programs (22.1-221).

Substance Abuse:

ee. Immunity of school personnel investigating or reporting alcohol or drug use (8.01-47).

ff. Drinking or possession of alcoholic beverages in or on public grounds (4-78.1).

gg. Drinking or possession of beverages in public schools or on public school grounds (4-112.4).

Environment:

hh. Minimum standards for public school buildings (22.1-138).

ATTENDANCE REQUIREMENTS

a. **§ 22.1-254.** Ages of children required to attend. - Every parent, guardian, or other person in the Commonwealth having control or charge of any child who will have reached the fifth birthday on or before October 31 of 1980-81 school year and September 30 of any school year thereafter and who has not passed the seventeenth birthday shall, during the period of each year the public schools are in session and for the same number of days and hours per day as the public schools, send such child to a public school or to a private, denominational or parochial school or have such child taught by a tutor or teacher of qualifications prescribed by the Board of Education and approved by the division superintendent or provide for home instruction of such child as described in §22.1-254.1.

b. **§ 22.1-270.** Preschool physical examinations. - A. No pupil shall be admitted for the first time to any public kindergarten or elementary school in a school division unless such pupil shall furnish, prior to admission (i) a report from a qualified licensed physician of a comprehensive physical examination of a scope prescribed by the State Health Commissioner performed no earlier than twelve months prior to the date such pupil first enters such public kindergarten or elementary school or (ii) records establishing that such pupil furnished such report upon prior admission to another school or school division and providing the information contained in such report.

B. The physician making a report of a physical examination required by this section shall, at the end of such report, summarize the abnormal physical findings, if any, and shall specifically state what, if any, conditions are found that would identify the child as handicapped.

C. Such physical examination report shall be placed in the child's health record at the school and shall be made available for review by any employee or official of the State Department of Health or any local health department at the request of such employee or official.

D. Such physical examination shall not be required of any child whose parent or guardian shall object on religious grounds and who shows no visual evidence of sickness provided that such parent or guardian shall state in writing that, to the best of his knowledge, such child is in good health and free from any communicable or contagious disease.

E. The health departments of all of the counties and cities of the Commonwealth shall conduct such physical examinations for medically indigent children without charge upon request and may provide such examinations to others on such uniform basis as such departments may establish.

F, G. [Repealed.]

H. The provisions of this section shall not apply to any child who was admitted to a public school prior to July 1, 1972.

I. Parents or guardians of entering students shall complete a health information form which shall be distributed by the local school divisions. Such forms shall be developed and provided jointly by the Department of Education and Department of Health, or developed and provided by the school division and approved by the Superintendent of Public Instruction. Such forms shall be returnable within fifteen days of receipt unless reasonable extensions have been granted by the superintendent or his designee. Upon failure of the parent or guardian to complete such form within the extended time, the superintendent may send to the parent or guardian written notice of the date he intends to exclude the child from school. (Code 1950, § 22-220.1; 1972, c. 761; 1973, c. 300; 1974, c. 160; 1979, cc. 120, 260; 1980, c. 559; 1982, c. 510; 1983, c. 195; 1985; c. 334.)

c. **§ 22.1-271.2.** **Immunization requirements.** - A. No student shall be admitted by a school unless at the time of admission the student or his parent or guardian submits documentary proof of immunization to the admitting official of the school or unless the student is exempted from immunization pursuant to subsection C. If a student does not have documentary proof of immunization, the school shall notify the student or his parent or guardian (i) that it has no documentary proof of immunization for the student; (ii) that it may not admit the student without proof unless the student is exempted pursuant to subsection C; (iii) that the student may be immunized and receive certification by a licensed physician or an employee of a local health department; and (iv) how to contact the local health department to learn where and when it performs these services. Neither this Commonwealth nor any school or admitting official shall be liable in damages to any person for complying with this section.

Any physician or local health department employee performing immunizations shall provide to any person who has been immunized or to his parent or guardian, upon request, documentary proof of immunizations conforming with the requirements of this section.

B. Any student whose immunizations are incomplete may be admitted conditionally if that student provides documentary proof at the time of enrollment of having received at least one dose of the required immunizations accompanied by a schedule for completion of the required doses within ninety days.

The immunization record of each student admitted conditionally shall be reviewed periodically until the required immunizations have been received.

Any student admitted conditionally and who fails to comply with his schedule for completion of the required immunizations shall be excluded from school until his immunizations are resumed.

C. No certificate of immunization shall be required for the admission to school of any student if (i) the student or his parent or guardian submits an affidavit to the admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices; or (ii) the school has written certification from a licensed physician or a local health department that one or more of the required immunizations may be detrimental to the student's health, indicating the specific nature and probable duration of the medical condition or circumstance that contraindicates immunization.

D. The admitting official of a school shall exclude from the school any student for whom he does not have documentary proof of immunization or notice of exemption pursuant to subsection C.

E. Every school shall record each student's immunizations on the school immunization record. The school immunization record shall be a standardized form provided by the State Department of Health, which shall be a part of the mandatory permanent student record. Such record shall be open to inspection by officials of the State Department of Health and the local health departments.

The school immunization record shall be transferred by the school whenever the school transfers any student's permanent academic or scholastic records.

Within thirty calendar days after the beginning of each school year or entrance of a student, each admitting official shall file a report with the local health department. The report shall be filed on forms prepared by the State Department of Health and shall state the number of students admitted to school with documentary proof of immunization, the number of students who have been admitted with a medical or religious exemption and the number of students who have been conditionally admitted.

F. The requirement for mumps immunization as provided in § 32.1-46 shall not apply to any child admitted for the first time to any grade level, kindergarten through grade twelve, of a school prior to August 1, 1981.

The requirement for Haemophilus Influenzae Type b immunization as provided in § 32.1-46 shall not apply to any child admitted to any grade level, kindergarten through grade twelve.

G. The Board of Health shall promulgate rules and regulations for the implementation of this section in congruence with rules and regulations of the Board of Health promulgated under § 32.1-46 and in cooperation with the Board of Education. (1982, c. 510; 1983, c. 433; 1988, c. 216; 1989, c. 382).

d. **§ 32.1-46. Immunization of children against certain diseases.** - A. The parent, guardian or person in loco parentis of each child within this Commonwealth shall cause such child to be immunized by vaccine against diphtheria, tetanus, whooping cough and poliomyelitis before such child attains the age of one year, against Haemophilus Influenzae Type b before he attains the age of thirty months, and against measles (rubeola), German measles (rubella) and mumps before such child attains the age of two years. All children shall also be required to receive a second dose of measle rubeola vaccine in accordance with the regulations of the Board. The Board's regulations shall require that all children receive a second dose of measles (rubeola) vaccine prior to first entering kindergarten or first grade and that all children who have not yet received a second dose of measle (rubeola) vaccine receive such second dose prior to entering the sixth grade. The parent, guardian or person in loco parentis may have such child immunized by a physician or may present the child to the appropriate local health department which shall administer the required vaccines without charge.

B. A physician or local health department administering a vaccine required by this section shall provide to the person who presents the child for immunizations a certificate which shall state the diseases for which the child has been immunized, the number of doses given, the dates when administered and any further immunizations indicated.

C. The vaccines required by this section shall meet the standards prescribed in, and be administered in accordance with, regulations to the Board.

D. The provision of this section shall not apply if:

1. The parent or guardian of the child objects thereto on the grounds that the administration of immunizing agents conflicts with his religious tenets or practices, unless an emergency or epidemic of disease has been declared by the Board, or

2. The parent or guardian presents a statement from a physician licensed to practice medicine in Virginia which states that the physical condition of the child is such that the administration of one or more of the required immunizing agents would be detrimental to the health of the child. (Code 1950, § 32-57.1; 1968, c. 592; 1972, c. 558; 1979, c. 711; 1980, c. 410; 1989, c. 382; 1991, c. 133; 1992, cc. 127, 166.)

The 1991 amendment, in subsection A, in the first sentence inserted "standing," and deleted "after such child attains the age of eighteen months and" following "Haemophilus influenzae type b," added the second sentence, and inserted "standing" in the third sentence; and delated the former last paragraph which stated: "The provisions of this section shall not operate so as to affect the eligibility of any child to be admitted to public schools in Virginia prior to August 1, 1981."

The 1992 amendments. - The 1992 amendments by cc.127 and 166 are identical, and in subsection A deleted "prior to entering kindergarten or first grade" following "of measles rubeola vaccine" in the second sentence, and added the third sentence.

The 1989 amendment, effective July 1, 1990, inserted the language beginning "against Haemophilus Influenza Type b," and ending "the age of thirty months" in the first sentence of subsection A.

e. **§ 32.1-47. Exclusion from school of children not immunized.** - Upon the identification of an outbreak, potential epidemic or epidemic of a vaccine-preventable disease in a public or private school, the Commissioner shall have the authority to require the exclusion from such school of all children who are not immunized against that disease. (1979, c. 711.)

f. **§ 22.1-3.1.** Birth Certificates required upon admission; required notice to the local law-enforcement agency. - A. No pupil shall be admitted for the first time to any public school in any school division in this Commonwealth unless the person enrolling the pupil shall present, upon admission, a certified copy of the pupil's birth record. The principal or his designee shall record the official state birth number from the pupil's birth record into the pupil's permanent school record. If a certified copy of the pupil's birth record cannot be obtained, the person so enrolling the pupil shall submit an affidavit setting forth the pupil's age and explaining the inability to present a certified copy of the birth record. If the school division cannot ascertain a child's age because of the lack of a birth certificate, the child shall nonetheless be admitted into the public schools if the division superintendent determines that the person submitting the affidavit presents information sufficient to estimate with reasonable certainty the age of such child.

B. Upon the failure of any person enrolling a pupil to present a certified copy of the pupil's birth record, the principal of the school in which the pupil is being enrolled or his designee shall immediately notify the local law-enforcement agency. The notice to the local law-enforcement agency shall include copies of the submitted proof of the pupil's identity and age and the affidavit explaining the inability to produce a certified copy of the birth record.

C. Within fourteen days after enrolling a transferred pupil, the principal of the school in which the pupil has been enrolled or his designee shall request that the principal or his designee of the school in which the pupil was previously enrolled submit documentation that a certified copy of the pupil's birth record was presented upon the pupil's initial enrollment.

D. Principals and their designees shall be immune from any civil or criminal liability in connection with any notice to a local law-enforcement agency of a pupil lacking a birth certificate or failure to give such notice as required by this section. (1990, c. 295; 1991, c. 523.)

The 1991 amendment, effective March 23, 1991, in subsection A in the first sentence substituted "present" for "furnish," and deleted "or other reliable proof pursuant to 22.1-4 of the pupil's identity and age" at the end of the first sentence, added the second sentence, in the third sentence inserted "setting forth the pupil's age," and substituted "present" for "produce," and added the last sentence; substituted "present" for "furnish" in the first sentence of subsection B; and in subsection C substituted "submit documentation that" for "transfer" and added "was presented upon the pupil's initial enrollment.

CONTAGIOUS DISEASES

g. **§ 22.1-272. Contagious and infectious diseases.** - Persons suffering with contagious or infectious disease shall be excluded from the public schools while in that condition. (Code 1950, § 22-249; 1968, c. 445; 1970, c. 526; 1973, c. 491; 1974, c. 160; 1977, c. 220; 1979, c. 262; 1980, c. 599.)

h. **§ 32.1-36.1. Confidentiality of test for human immunodeficiency virus; civil penalty; individual action for damages or penalty.** - A. The results of every test to determine infection with human immunodeficiency virus shall be confidential. Such information may only be released to the following persons:

1. The subject of the test or his legally authorized representative.
2. Any person designated in a release signed by the subject of the test or his legally authorized representative.
3. The Department of Health.
4. Health care providers for purposes of consultation or providing care and treatment to the person who was the subject of the test.
5. Health care facility staff committees which monitor, evaluate, or review programs or services.
6. Medical or epidemiological researchers for use as statistical data only.
7. Any person allowed access to such information by a court order.
8. Any facility which procures, processes, distributes or uses blood, other body fluids, tissues or organs.
9. Any person authorized by law to receive such information.
10. The parents of the subject of the test if the subject is a minor
11. The spouse of the subject of the test.

B. In any action brought under this section, if the court finds that a person has willfully or through gross negligence made an unauthorized disclosure in violation of this section, the Attorney General, any attorney for the Commonwealth, or any attorney for the county, city or town in which the violation occurred may recover for the Literary Fund, upon petition to the court, a civil penalty of not more than $5,000 per violation.

C. Any person who is the subject of an unauthorized disclosure pursuant to this section shall be entitled to initiate an action to recover actual damages, if any, or $100, whichever is greater. In addition, such person may also be awarded reasonable attorney's fees and court costs.

D. This section shall not be deemed to create any duty on the part of any person who receives such test results, where none exists otherwise, to release the results to a person listed herein as authorized to receive them. (1989, c. 613; 1990, c. 777.)

i. **§ 22.1-271.3.** **Guidelines for school attendance for children infected with human immunodeficiency virus.** - A. The Board of Education, in cooperation with the Board of Health, shall develop, and revise as necessary, model guidelines for school attendance for children infected with human immunodeficiency virus. The first such guidelines shall be completed by December 1, 1989. The Board shall distribute copies of these guidelines to each division superintendent and every school board member in the Commonwealth immediately following completion.

B. Each school board shall, by July 1, 1990, adopt guidelines for school attendance for children with human immunodeficiency virus. Such guidelines shall be consistent with the model guidelines for such school attendance developed by the Board of Education. (1989, c. 613.)

j. **§ 32.1-38.** **Immunity from liability.** - Any person making a report or disclosure required or authorized by this chapter shall be immune from civil liability or criminal penalty connected therewith unless it is proved that such person acted with gross negligence or malicious intent. Further, except for such reporting requirements as may be established in this chapter or by an regulation promulgated pursuant thereto, there shall be no duty on the part of any blood collection agency or tissue bank to notify any other person of any reported test results, and a cause of action shall not arise from any failure by such entities to notify others. Neither the Commissioner nor any local health director shall disclose to the public the name of any person reported or the name of any person making a report pursuant to this chapter. (Code 1950, § 32-48; 1976, c. 628; 1979, c. 711; 1988, c. 130; 1990, c. 777.)

The 1988 amendment inserted "or authorized" in the first sentence and inserted "any person reported or the name of" in the second sentence.

The 1990 amendment, in the first sentence, inserted "or disclosure," and inserted "gross negligence or"; and added to the second sentence.

k. **§ 32.1-37.** **Reports by persons other than physicians.** The person in charge of any medical care facility, school or summer camp as defined in § 35.1-1 shall immediately make or cause to be made a report of a disease required by the Board to be reported when such information is available to that person and that person has reason to believe that no physician has reported such disease as provided in § 32.1-36. Such report shall be made by telephone or in person to the local health director or to the Commissioner. (Code 1950, § 32-49; 1979, c. 711.)0

l. **§ 32.1-39. Surveillance and investigation.** The Board shall provide for the surveillance of and investigation into all preventable diseases and epidemics in this Commonwealth and into the means for the prevention of such diseases and epidemics. Surveillance and investigation may include contact tracing in accordance with the regulations of the Board. When any outbreak or unusual occurrence of a preventable disease shall be identified through reports required pursuant to Article 1 (§ 32.1-35 et seq.) of this chapter, the Commissioner or his designee shall investigate the disease in cooperation with the local health director or directors in the area of the disease. If in the judgment of the Commissioner the resources of the locality are insufficient to provide for adequate investigation, he may assume direct responsibility and exclusive control of the investigation, applying such resources as he may have at his disposal. The Board may issue emergency regulations and orders to accomplish the investigation. (Code 1950, §§ 32-10, 32-42; 1979, c. 711; 1989, c. 613.)

m. **§ 22.1-300. Tuberculosis certificate.** - As a condition to employment, every public school employee, including without limitation teachers, cafeteria workers, janitors and bus drivers, shall submit a certificate signed by a licensed physician stating that such employee appears free of communicable tuberculosis. Such certificate shall be based on recorded results of such skin tests, x-rays and other examinations, singly or in combination, as are deemed necessary by the physician that have been performed within the twelve months' period immediately preceding submission of the certificate. After consulting with the local health director, any school board may require the submission of such certificates annually, or at such intervals as it deems appropriate, as a condition to continued employment. (Code 1950, 22-249; 1968, c. 445; 1970, c. 526; 1973, c. 491, 1974, c. 160; 1977, c. 220; 1979, c. 262; 1980, c. 559).

CHILD ABUSE AND NEGLECT

n. **§ 63.1-248.2.** Definitions. - As used in this chapter unless the context requires a different meaning:

A. "Abused or neglected child" means any child less than eighteen years of age:

1. Whose parents or other person responsible for his care creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon such child a physical or mental injury by other than accidental means, or creates a substantial risk of death, disfigurement, or impairment of bodily or mental functions;

2. Whose parents or other person responsible for his care neglects or refuses to provide care necessary for his health. However, no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall for that reason alone be considered to be an abused or neglected child;

3. Whose parents or other person responsible for his care abandons such child;

4. Whose parents or other person responsible for his care commits or allows to be committed any act of sexual exploitation or any sexual act upon a child in violation of the law; or

5. Who is without parental care or guardianship caused by the unreasonable absence or the mental or physical incapacity of the child's parent, guardian, legal custodian or other person standing in loco parentis.

B. "Department" means the State Department of Social Services.

C. "Local department" means the department of public welfare or social services of any county or city in this Commonwealth.

D. "Report" means an official document on which information is given concerning abuse and neglect and which is required to be made by persons designated herein and by local departments in those situations in which investigation of a complaint from the general public reveals suspected abuse or neglect.

E. "Complaint" means any information or allegation of abuse or neglect made orally or in writing other than the reports referred to above.

F. "The court" means the juvenile and domestic relations district court of the county or city.

Nothing in this section shall relieve any person specified in § 63.1-248.3 from making reports required in that section, regardless of the identity of the person suspected to have caused such abuse or neglect. (1975, c. 341; 1981, c. 123; 1986, c. 308; 1990, c. 760.)

The 1990 amendment rewrote the introductory paragraph; substituted "means" for "shall mean" throughout the section; divided subdivision 2 into two sentences by substituting "However" for "provided, however, that"; and added the last paragraph.

Law Review. - For a comment on student rights in Virginia public schools, see 22 U. Rich. L. Rev. 241 (1988).

o. **§ 63.1-248.3.** **Physicians, nurses, teachers, etc., to report certain injuries to children; penalty for failure to report.** - A. Any person licensed to practice medicine or any of the healing arts, any hospital resident or intern, any person employed in the nursing profession, any person employed as a social worker, any probation officer, any teacher or other person employed in a public or private school, kindergarten or nursery school, any person providing full or part-time child care for pay on a regularly planned basis, any duly accredited Christian Science practitioner, any mental health professional, any law-enforcement officer, in his professional or official capacity and any professional staff person, not previously enumerated, employed by a private or state-operated hospital, institution or facility which children have been committed to or placed in for care and treatment who has reason to suspect that a child is an abused or neglected child, shall report the matter immediately, except as hereinafter provided, to the local department of the county or city wherein the child resides or wherein the abuse or neglect is believed to have occurred. If neither locality is known, then such report shall be made to the local department of the county or city where the abuse or neglect was discovered. If an employee of the local department is suspected of abusing or neglecting a child, the report shall be made to the juvenile and domestic relations district court of the county or city where the abuse or neglect was discovered. If the information is received by a teacher, staff member, resident, intern or nurse in the course of professional services in a hospital, school or similar institution, such person may, in place of said report, immediately notify the person in charge of the institution or department, or his designee, who shall make such report forthwith. The initial report may be an oral report but such report shall be reduced to writing by the child abuse coordinator of the local department on a form prescribed by the State Board of Social Services. The person required to make the report shall disclose all information which is the basis for his suspicion of abuse or neglect of the child and, upon request, shall make available to the child-protective services coordinator and the local department investigating the reported case of child abuse or neglect any records or reports which document the basis for the report.

B. Any person required to file a report pursuant to subsection A of this section who is found guilty of failure so to do shall be fined not more than $500 for the first failure and for any subsequent failures not less than $100 nor more than $1000. (1975, c. 341; 1976, c. 348; 1978, c. 747.)

p. **§ 63.1-248.5.** **Immunity of person making report, etc., from liability.** - Any person making a report pursuant to § 63.1-248.3, a complaint pursuant to § 63.1-248.4, or who takes a child into custody pursuant to § 63.1-248.9, or who participates in a judicial proceeding resulting therefrom shall be immune from any civil or criminal liability in connection therewith, unless it is proven that such person acted in bad faith or with malicious intent. (1975, c. 341; 1988, c. 686.)

q. **§ 63.1-248.10.** Authority to talk to child or sibling. - Any person required to make a report or investigation pursuant to this chapter may talk to any child suspected of being abused or neglected or to any of his siblings without consent of and outside the presence of his parent, guardian, legal custodian, or other person standing in loco parentis, or school personnel. (1975, c. 341; 1979, c. 453; 1986, c. 308.)

The 1986 amendment substituted "of and outside the presence of his parent, guardian, legal custodian, or other person standing in loco parentis, or school personnel" for "of his parent or guardian."

r. **§ 63.1-248.17.** Cooperation by state entities. - All law-enforcement departments and other state and local departments, agencies, authorities and institutions shall cooperate with each child-protective services coordinator of a local department and any multi-discipline teams in the detection and prevention of child abuse. (1975, c. 371.)

SCHOOL HEALTH PERSONNEL

s. **§ 22.1-274. (Effective July 1, 1992)** School health services. - A school board shall provide pupil personnel and support services in compliance with § 22.1-253.13:2. A school board may employ school nurses, physicians, physical therapists, occupational therapists and speech therapists. No such personnel shall be employed unless they meet such standards as may be determined by the Board of Education. Subject to the approval of the appropriate local governing body, a local health department may provide personnel for health services for the school division. (Code 1950, § 22-241; 1956, c. 565; 1980, c. 559; 1990, c. 797; 1991, c. 295.)

Editor's note. - Acts 1990, c. 797, which amended this section, in cl. 3 provided that the provisions of the 1990 act would become effective July 1, 1992. However, Acts 1991, c. 295, cl. 1 amended Acts 1990, c. 797, cl. 3, to make the amendatory provisions of the 1990 act effective July 1, 1991.

The 1990 amendment added the language beginning "shall provide pupil personnel" in the first sentence, and added "A school board" in the second sentence. For effective date, see Editor's note.

Referenced in section 22.1-174:

§ 22.1-253.13:2. Standard 2. Support services. - A. The General Assembly and the Board of Education believe that effective schools must provide and maintain adequate support services to ensure quality education.

B. The Board of Education shall provide to the local school divisions technical assistance in the delivery of those support services which are necessary for the operation and maintenance of the public schools. Such technical services shall include, but not be limited to, in-service training of staff, development of appropriate facility plans, specifications for equipment, technology updates, and inspections of school buses.

C. Each local school board shall provide these support services which are necessary for the operation and maintenance of its public schools including, but not limited to, administration, instructional support, student attendance and health, operation and maintenance of the buildings and management information systems.

D. Each local school board shall also provide a program of pupil personnel services for grades K through 12 which shall be designed to aid students in their educational, social and career development.

E. Pursuant to the appropriations act, support services shall be funded from basic school aid on the basis of prevailing statewide costs. (1988,. cc. 645, 682.)

Note:

The Standards of Quality were revised effective July 1, 1992 as indicated in Supts. memo No 183, August 21, 1992.

VISION AND HEARING SUPPORT

t. **§ 22.1-273.** **Sight and hearing of pupil to be tested.** - The Superintendent of Public Instruction shall prepare or cause to be prepared, with the advice and approval of the State Health Commissioner, suitable test cards, blanks, record books, and other appliances for testing the sight and hearing of the pupils in the public schools and necessary instructions for the use thereof. The State Department of Education shall furnish the same free of expense to all schools in a school division upon request of the school board of such division accompanied by a resolution of the school board directing the use of such test cards, blanks, record books and other appliances in the schools of the school division. Within a time period to be established by the Board of Education, the principal of each such school shall test the sight and hearing of all pupils in the school and keep a record of such examinations in accordance with instructions furnished. Whenever a pupil is found to have any defect of vision or hearing or a disease of the eyes or ears, the principal shall forthwith notify the parent or guardian, in writing, of such defect or disease. Copies of the report shall be preserved for the use of the Superintendent of Public Instruction as he may require. (Code 1950, § 22-248; 1980, c. 559; 1981, c. 142.)

ADVISORY BOARD

u. **§ 22.1-275.1. School health advisory board.**- Each school board shall establish a school health advisory board of no more than twenty members which shall consist of broad-based community representation including, but not limited to, parents, students, health professionals, educators, and others. The school health advisory board shall assist with the development of health policy in the school division and the evaluation of the status of school health, health education, the school environment, and health services.

The school health advisory board shall hold meetings at least semi-annually and shall annually report on the status and needs of student health in the school division to any relevant school, the school board, the Virginia Department of Health, and the Virginia Department of Education. (1990, c. 315; 1992, c. 174.)

HEALTH CARE FOR MINORS/EMERGENCY CARE

v. **§ 54.1-2969.** **Authority to consent to surgical and medical treatment of certain minors.** - A. Whenever any minor who has been separated from the custody of his parent or guardian is in need of surgical or medical treatment, authority commensurate with that of a parent in like cases is conferred, for the purpose of giving consent to such surgical or medical treatment, as follows:

1. Upon judges with respect to minors whose custody is within the control of their respective courts.

2. Upon local superintendents of public welfare or social services or their designees with respect to (i) minors who are committed to the care and custody of the local board by courts of competent jurisdiction, (ii) minors who are taken into custody pursuant to § 63.1-248.9 of the Code and (iii) minors who are entrusted to the local board by the parent, parents or guardian, when the consent of the parent or guardian cannot be obtained immediately and, in the absence of such consent, a court order for such treatment cannot be obtained immediately.

3. Upon the Director of Department of Corrections or the Director of the Department of Youth Services or his designees with respect to any minor who is sentenced or committed to his custody.

4. Upon the principal executive officers of state institutions with respect to the wards of such institutions.

5. Upon the principal executive officer of any other institution or agency legally qualified to receive minors for care and maintenance separated from their parents or guardians, with respect to any minor whose custody is within the control of such institution or agency.

6. Upon any person standing in loco parentis, or upon a conservator or custodian for his ward or other charge under disability.

B. Whenever the consent of the parent or guardian of any minor who is in need of surgical or medical treatment is unobtainable because such parent or guardian is not a resident of this Commonwealth or his whereabouts is unknown or he cannot be consulted with promptness reasonable under the circumstances, authority commensurate with that of a parent in like cases is conferred, for the purpose of giving consent to such surgical or medical treatment, upon judges of juvenile and domestic relations district courts.

C. Whenever delay in providing medical or surgical treatment to a minor may adversely affect such minor's recovery and no person authorized in this section to consent to such treatment for such minor is available within a reasonable time under the circumstances, no liability shall be imposed upon a licensed health professional or licensed hospital by reason of lack of consent to such medical or surgical treatment. However, in the case of a minor fourteen years of age or older who is physically capable of giving consent, such consent shall be obtained first.

D. A minor shall be deemed an adult for the purpose of consenting to:

1. Medical or health services needed to determine the presence of or to treat venereal disease or any infectious or contagious disease which the State Board of Health requires to be reported;

2. Medical or health services required in case of birth control, pregnancy or family planning except for the purposes of sexual sterilization;

3. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for substance abuse as defined in § 37.1-203;

4. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance.

E. Except for the purposes of sexual sterilization, any minor who is or has been married shall be deemed an adult for the purpose of giving consent to surgical and medical treatment.

F. Any minor seventeen years of age may, with the consent of a parent or legal guardian, consent to donate blood and may donate blood if such minor meets donor eligibility requirements. However, parental consent to donate blood by any minor seventeen years of age shall not be required if such minor receives no consideration for his blood donation and the procurer of the blood is a nonprofit, voluntary organization.

G. Any judge, local superintendent of public welfare or social services, Director of the Department of Corrections, Director of the Department of Youth Services, or principal executive officer of any state or other institution or agency who consents to surgical or medical treatment of a minor in accordance with this section shall make a reasonable effort to notify the minor's parent or guardian of such action as soon as practicable. (Code 1950, § 32-137; 1968, c. 71; 1970, c. 232, § 54-325.2; 1971, Ex. Sess., c. 183; 1972, cc. 323, 823; 1973, c. 337; 1974, cc. 44, 45, 639; 1977, cc. 523, 525; 1978, cc. 10, 401; 1979, c. 720; 1981, cc. 22, 454, 573; 1984, c. 72; 1988, c. 765; 1989, c. 733.)

w. **§ 8.01-225. Persons rendering emergency care, obstetrical services exempt from liability.** - A. Any person who, in good faith, renders emergency care or assistance, without compensation, to any ill or injured person at the scene of an accident, fire, or any life-threatening emergency, or enroute there from to any hospital, medical clinic or doctor's office, shall not be liable for any civil damages for acts or omissions resulting from the rendering of such care or assistance.

Any person who, in the absence of gross negligence, renders emergency obstetrical care or assistance to a female in active labor who has not previously been cared for in connection with the pregnancy by such person or by another professionally associated with such person and whose medical records are not reasonably available to such person shall not be liable for any civil damages for acts or omissions resulting from the rendering of such emergency care or assistance. The immunity herein granted shall apply only to the emergency medical care provided.

Any person who, in good faith and without compensation, administers epinephrine to an individual for whom an insect sting treatment kit has been prescribed shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment if he has reason to believe that the individual receiving the injection is suffering or is about to suffer a life-threatening anaphylactic reaction.

Any person having attended and successfully completed a course in cardiopulmonary resuscitation, which has been approved by the State Board of Health, who in good faith and without compensation renders or administers emergency cardiopulmonary resuscitation, cardiac defibrillation or other emergency life-sustaining or resuscitation treatments or procedures which have been approved by the State Board of Health to any sick or injured person, whether at the scene of a fire, an accident or any other place, or while transporting such person to or from any hospital, clinic, doctor's office or other medical facility, shall be deemed qualified to administer such emergency treatments and procedures; and such individual shall not be liable for acts or omissions resulting from the rendering of such emergency resuscitative treatments or procedures.

Note:

Complete section of code is not provided here, additional parts of this section describe care provided at the request of any police agency, fire department, etc.; emergency medical attendant care; and licensed physicians serving without compensation when rendering emergency medical services.

SAFETY AND CLEAN AIR

x. **§ 22.1-275. Protective eye devices.** - Every student and teacher in any school, college, or university shall be required to wear industrial quality eye protective devices while participating in any of the following courses or laboratories:

1. Vocational or industrial arts shops or laboratories involving experience with:
    a. Hot molten metals,
    b. Milling, sawing, turning, shaping, cutting, grinding, or stamping of any solid materials,
    c. Heat treatment, tempering, or kiln firing of any metal or other materials,
    d. Gas or electric arc welding,
    e. Repair of any vehicle,
    f. Caustic or explosive materials;
2. Chemical or combined chemical-physical laboratories involving caustic or explosive chemicals or hot liquids or solids.

The governing board or authority of any public or private school or the governing body of each institution of a higher learning shall furnish the eye protective devices prescribed in this section free of charge or at cost to the students and teachers of the school participating in such courses or laboratories; provided, however, that such devices may be furnished by parents or guardians of such students. Eye protective devices shall be furnished to all visitors to such courses.

"Industrial quality eye protective devices," as used in this section, means devices providing side protection and meeting the standards of the American Standards Association Safety Code for Head, Eye, and Respiratory Protection, Z2.1-1959, promulgated by the American Standards Association, Inc. (Code 1950, § 22-10.2; 1966, c. 69; 1980, c.559.)

y. **§ 22.1-274.1. Criteria to identify toxic art materials; labeling; use in certain grades prohibited.** - The State Department of Education, in cooperation with the State Department of Health, shall develop criteria to identify toxic art materials.

After these criteria have been developed, the Department of Education shall require school divisions to evaluate all art materials used in schools and identify those which are toxic. All materials used in the public schools which meet the criteria as toxic shall be so labeled and the use of such art materials shall be prohibited in kindergarten through grade five. (1987, c. 225; 1988, c. 103.)

The 1988 amendment deleted the last sentence in paragraph one which read "These criteria shall be available by July 1, 1988," inserted "require school divisions to" and substituted "kindergarten through grade five" for "the elementary grades."

z. **Virginia Indoor Clean Air Act** (Complete code is extensive and full text is not given here; appropriate excerpts are provided.)

§ 15.1-291.1. Definitions. - As used in this chapter unless the context requires a different meaning:

"Educational facility" means any building used for instruction of enrolled students, including, but not limited to, any day-care center, nursery school, public or private school, college, university, medical school, or vocational school.

"Health care facility" means any institution, place, building, or agency required to be licensed under Virginia law, including, but not limited to, any hospital, nursing home, boarding home, adult home, supervised living facility, or ambulatory medical and surgical center.

"Person" means any person, firm, partnership, association, corporation, company, or organization of any kind.

"Proprietor" means the owner or lessee of the public place, who ultimately controls the activities within the public place. The term "proprietor" includes corporations, associations, or partnerships as well as individuals.

"Public conveyance" or "public vehicle" means any air, land, or water vehicle used for the mass transportation of persons in intrastate travel for compensation, including, but not limited to, any airplane, train, bus, or boat that is not subject to federal smoking regulations.

"Public place" means any enclosed, indoor area used by the general public, including, but not limited to, any building owned or leased by the Commonwealth or any agency thereof or any county, city, or town, public conveyance or public vehicle, restaurant, educational facility, hospital, nursing home, other health care facility, library, retail store of 15,000 square feet or more, auditorium, arena, theater, museum, concert hall, or other area used for a performance or an exhibit of the arts or sciences, or any meeting room.

"Smoke" or "smoking" means the carrying or holding of any lighted pipe, cigar, or cigarette of any kind, or any other lighted smoking equipment, or the lighting, inhaling, or exhaling of smoke from a pipe, cigar, or cigarette of any kind.

§ 15.1-291.2. Statewide regulation of smoking. - A. The Commonwealth or any agency thereof and every county, city, or town shall provide reasonable no-smoking areas, considering the nature of the use and the size of the building, in any building owned or leased by the Commonwealth or any agency thereof or a county, city, or town. The provisions of this chapter shall not apply to office, work or other areas of the Department of Corrections which are not entered by the general public in the normal course of business or use of the premises.

B. Smoking shall be prohibited in (i) elevators, regardless of capacity, except in any open material hoist elevator, not intended for use by the public; (ii) public school buses; (iii) common areas in any public elementary, intermediate, and secondary school, including, but not limited to classrooms, libraries, hallways, auditoriums, and other facilities; (iv) hospital emergency rooms; (v) local or district health departments; (vi) polling rooms; and (vii) indoor service lines and cashier lines.

D. The proprietor or other person in charge of an educational facility, health care facility, or a retail establishment of 15,000 square feet or more serving the general public, including, but not limited to, department stores, grocery stores, drug stores, clothing stores, and shoe stores, shall designate reasonable no-smoking areas, considering the nature of the use and the size of the building.

E. The proprietor or other person in charge of a space subject to the provisions of this chapter shall post signs stating "Smoking Permitted" or "No Smoking," and in restaurants, signs conspicuous to ordinary public view at or near each public entrance stating "No-Smoking Section Available." Any person failing to post such signs may be subject to a civil penalty of not more than twenty-five dollars.

§ 15.1-291.5. Mandatory provisions of local ordinances. - Any local ordinance shall provide that it is unlawful for any person to smoke in any of the following places:

1. Elevators, regardless of capacity;
2. Common areas in an educational facility, including, but not limited to, classrooms, hallways, auditoriums, and public meeting rooms;
3. Any part of a restaurant designated a "no-smoking" area pursuant to the provisions of this chapter;
4. Indoor service lines and cashier areas; and
5. School buses and public conveyances. (1990, cc. 902, 969.)

SPECIAL EDUCATION

Special Education (complete text is not included):

aa. **§ 22.1-213. __Definitions.__** - As used in this article:

"Handicapped children" means those persons (i) who are aged two to twenty-one, inclusive, having reached the age of two by the date specified in § 22.1-254, (ii) who are mentally retarded, physically handicapped, seriously emotionally disturbed, speech impaired, hearing impaired, visually impaired, multiple handicapped, other health impaired including autistic or who have a specific learning disability or who are otherwise handicapped as defined by the Board of Education and (iii) who because of such impairments need special education.

"Related services" means transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education, including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training.

"Special education" means specially designed instruction at no cost to the parent, to meet the unique needs of a handicapped child, including classroom instruction, home instruction, instruction provided in hospitals and institutions, instruction in physical education and instruction in vocational education.

"Specific learning disability" means a disorder in one or more of the basic psychological processes involved in understanding or using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations. The term does not include children who have learning problems which are primarily the result of visual, hearing or motor handicaps, of mental retardation, or of environmental, cultural or economic disadvantage. (Code 1950, § 22-10.3; 1974, c. 480; 1978, c. 386; 1980, c. 559; 1983, c. 538; 1990, c. 444.)

bb. **§ 22.1-214. __Board to prepare special education program for handicapped children.__** - A. The Board of Education shall prepare and supervise the implementation by each school division of a program of special education designed to educate and train handicapped children between the ages defined in § 22.1-213 and may prepare and place in operation such program for such individuals of other ages. The program developed by the Board of Education shall be designed to ensure that all handicapped children have available to them a free and appropriate education, including specially designed instruction to meet the unique needs of such children. The program shall require (i) that the hearing of each handicapped child be tested prior to placement in a special education program and (ii) that a complete audiological assessment, including tests which will assess inner and middle ear functioning, be performed on each child who is hearing impaired or who fails the test required in (i) hereof. The school boards of the several school divisions, the Department for the Visually Handicapped, the Department for the Deaf and Hard-of Hearing, the Department of Health and other state and local agencies which can or may be able to assist in providing educational and related services shall assist and cooperate with the Board of Education in the development of such program.

cc. **§ 22.1-217.** **Visually impaired children.** - A. Special education for visually impaired children provided by a school division shall be established, maintained and operated jointly by the school board and the Virginia Board for the Visually Handicapped subject to the regulations of the Board of Education. Consideration shall be given to including Braille instruction in the student's Individualized Education Plan (IEP), whenever appropriate.

B. The Virginia Board for the Visually Handicapped shall prepare and place in operation a program of special education services in addition to the special education provided in the public school system designed to meet the educational needs of visually impaired children between the ages of birth and twenty-one and may prepare and place in operation such programs for such individuals of other ages. In the development of such a program, the Virginia Board for the Visually Handicapped shall cooperate with the Board of Education and the school boards of the several school divisions.

C. As used in this section:

1. "Visually impaired" shall be defined by the Board of Education and the Virginia Board for the Visually Handicapped.

2. "Program" means a modified program which provides special materials or services and may include the employment of itinerant teachers or resource room teachers for the visually impaired. (Code 1950, § 22-10.7; 1974, c. 480; 1978, c. 386; 1980, c. 559; 1990, c. 803.)

dd. **§ 22.1-221.** **Transportation of handicapped children attending public or private special education programs.** - A. Each handicapped child enrolled in and attending a special education program provided by the school division pursuant to any of the provisions of § 22.1-216 or § 22.1-218 shall be entitled to transportation to and from such school or class at no cost if such transportation is necessary to enable such child to obtain the benefit of educational programs and opportunities.

B. A school board may, in lieu of providing transportation on an approved school bus, allot funds to pay the reasonable cost of special arrangement transportation. The Board of Education shall reimburse the school board sixty percent of such cost if funds therefore are available.

C. Costs for operating approved school buses while used exclusively for transporting handicapped children shall be reimbursed according to the regulations promulgated by the Board of Education from such state funds as are appropriated for this purpose. (Code 1950, § 22-10.11; 1974, c. 480; 1975, cc. 464, 513; 1978, c. 386; 1980, c. 559; 1983, c. 521.)

Cross reference. - For provisions authorizing school boards to provide for the transportation of pupils generally, see § 22.1-176. **Applied** in Pinkerton v. Moye, 509 F. Supp. 107 (W.D. Va. 1981).

SUBSTANCE ABUSE

Substance abuse, violence, weapons, trespassing are covered extensively by the Code; full coverage of these issues may be obtained from building administrator.

ee. **§ 8.01-47. Immunity of school personnel investigating or reporting alcohol or drug use.** - In addition to any other immunity he may have, any teacher, instructor, principal, school administrator, school coordinator, guidance counselor or any other professional, administrative or clerical staff member or other personnel of any elementary or secondary school, or institution of higher learning who, in good faith with reasonable cause and without malice, acts to report, investigate or cause any investigation to be made into the activities of any student or students or any other person or persons as they relate to alcohol or drug use or abuse in or related to the school or institution or in connection with any school or institution activity, shall be immune from all civil liability that might otherwise be incurred or imposed as the result of the making of such a report, investigation or disclosure. (Code 1950, § 8-631.1; 1972, c. 762; 1977, c. 617; 1982, c. 259; 1988, c. 159.)

ff. **§ 4-78.1. Drinking or possession of alcoholic beverages in or on public school grounds.** - If any person, in or upon the grounds of any free public elementary or secondary school, during school hours or school or student activities, takes a drink of any alcoholic beverage or has in his possession any alcoholic beverage, he shall be guilty of a misdemeanor punishable by confinement in jail for not more than six months and a fine of not more than $1,000 either or both. (1954, c. 651; 1982, c. 288; 1991, c. 710.)

The 1991 amendment, effective April 3, 1991, substituted "takes" for "shall take," substituted "or has" for "or have," and substituted $1,000 for "$500."

gg. § 4-112.4. **Drinking or possession of beverages in public schools or on public school grounds.** - If any person, in or upon the grounds of any free public elementary or secondary school, during school hours or during school or student activities, takes a drink of any beverage as defined in this chapter or has in his possession any such beverage, he shall be guilty of a misdemeanor punishable by confinement in jail for not more than six months and a fine of not more than $1,000, either or both. (1981, c. 381; 1982, c. 288; 1991, c. 710.)

ENVIRONMENT

hh. § **22.1-138.** **Minimum standards for public school buildings.** - The Board of Education shall prescribe by regulations minimum standards for the erection of or addition to public school buildings governing instructional, operational, health and maintenance facilities where these are not specifically addressed in the Uniform Statewide Building Code. (1980, c. 559.)

EVALUATION OF SCHOOL HEALTH SERVICES

OVERVIEW

Legal Basis

The following should be considered in establishing evaluation criteria:

- Standards for Accrediting Public Schools in Virginia, Department of Education, July 1988.

- Standards of Quality for Public Schools in Virginia, Board of Education, July 1990.

- Related policies.

Recommendation

Functions

A comprehensive school health program has four basic functions:

- To deliver health services to students and staff

- To provide health instruction

- To provide a safe and healthful school environment

- To serve as an advocate for children and youth

These functions may be developed, implemented, and evaluated independently. Health instruction is most frequently regulated through the curriculum and instruction departments of individual school systems. Guidance for maintaining a safe and healthful school environment come from varied sources such as environmental health services of local health departments, risk management services within school divisions, safe-schools programs, and state and local building codes and ordinances.

Evaluation

Evaluation of school health services rendered to students and staff is necessary if the needs of students, school personnel, and the community are to be met. Evaluation is or should be a learning process. An evaluation is a set of systematic procedures to appraise a program and/or provide information about the program's goals, activities, outcomes, and costs in order to make program improvements.

Purpose

The main purposes of evaluation are to:

- Assess the effectiveness of a program in achieving its objectives
- Identify strengths and weaknesses of a program
- Monitor standards of practice - a quality assurance process

The evaluation results will assist school health administrators to focus on current needs, including implications for costs versus benefits in each phase of the school health program. The results will indicate modifications that are needed in a program as well as practices that should be discontinued because that have no effect on the health status of students.

A program must be evaluated for its current and future worth. Any program revolving around school children undergoes constant change. More and more school programs are being required to produce evidence of their effectiveness and efficiency by documenting program achievements.

Role of the School Nurse

Evaluation of school health services may be done by the school division's school nurse coordinator or school nurse if there is no coordinator position. However, use of a school nurse, school nurse coordinator, or school health nursing consultant from outside the school division will usually result in a more objective evaluation of the program. A peer review can usually be arranged with a school nurse from a nearby school or school division.

Guidelines for Evaluation of School Health Services:

The evaluation criteria are divided into two major divisions, each with several sections. They are:

- General School Health Services
- Specific School Health Services

The school nurse coordinator conducting the evaluation reviews all policies and procedures of the school division and asks for additional documents, data, forms, and records that will assist in determining the level of practice and quality of the program. Notations are to be made on the evaluation form that will assist in providing the necessary information needed to make recommendations for improvement or to identify an exemplary program.

Resources:

For more detailed and in-depth evaluation guidance, nursing personnel may refer to An Evaluation Guide for School Nursing Practice Designed for Self and Peer Review, which is used in conjunction with Standards of School Nursing Practice.

Please see Appendix C-2 for an example of an evaluation form that can be completed by a non-nurse administrator entitled "School Nurse performance Evaluation Data Input/Site Administrators."

Reference

Adapted from: Colorado School Health Guidelines; Chapter IX and Exhibit XV. Colorado Department of Education and Colorado Department of Health, Second Edition, 1986.

GUIDELINES

Legal Basis

The following should be considered in establishing evaluation guidelines:

- Standards for Accrediting Public Schools in Virginia, Department of Education, July 1988.
- Standards of Quality for Public Schools in Virginia, Board of Education, July 1990.
- Related policies.

Recommendation

Please see the following "Guidelines for Evaluation of School Health Services."

GUIDELINES FOR EVALUATION OF SCHOOL HEALTH SERVICES

Criteria	Documentation or Comments
I. General School Health Services	
A. Purposes and scope of the school health program have been defined by written policies	
B. Specific, written school health procedures are available for:	
1. Emergency care of ill or injured students	
2. Medications given in the schools (including appropriate storage under double lock)	
3. Control of communicable disease	
4. Reporting child abuse	
5. Compliance with immunization law	
6. Health component of Education of all Handicapped Children Act	
C. Responsibilities of different classifications of school health personnel are clearly defined and applied	
D. Community health resources are used in the school health program	
E. A school health council or committee of school and community people has been organized and is functioning effectively	

Criteria	Documentation or Comments
F. Consultative Services:	
1. Physicians are available for consultation and advice	
2. Dentists are available for consultation and advice	
3. The public health nursing department is available to the schools	
G. Adequately trained first aid personnel are available and on duty at all times during the school day and school sponsored activities	
H. Cumulative health records are maintained K-12 on all students and include	
1. Major health problems which may be significant educationally or pertain to the child's safety or the safety of others with whom the child interacts	
2. Designated screening programs are recorded for both pass and fail	
3. All health information obtained on the student is recorded on and/or filed in the health record	
4. Health records are readily accessible to appropriate school personnel	
5. Health records are kept in locked files	

Criteria	Documentation or Comments
I. The school health services program undergoes periodic evaluation and revision	
II. SPECIFIC SCHOOL HEALTH SERVICES	
A. There is written job description for the school nurse	
B. There is a written job description for the health clerk and other health service personnel, such as technicians, school physicians, and health aides	
C. There are written objectives for the school nursing program	
D. A qualified school nurse supervisor, coordinator, or consultant is available to give direction and advice	
E. School nurses are licensed to practice within the state of Virginia	
F. Channels of communication between the supervisor, administrator, and staff are clearly established and understood	
G. The number of health personnel is adequate to fulfill the objectives of the school health service program and/or to meet the standards recommended by the Task Force on Standards of School Health Nursing Practice: 1:750 in general school populations 1:225 in mainstreamed populations 1:125 severely/profoundly handicapped populations	

Criteria	Documentation or Comments
H. Inservice training is available and a reasonable amount of release time is available to permit health personnel to attend staff meetings, workshops, and continuing education programs	
I. Individual staff evaluations are conducted by peer and/or supervisor	
J. Health Assessments by the school nurse are:	
1. Completed on all kindergarten students	
2. Completed on all new students in the school division	
3. Completed on students enrolled in special educational programs	
4. Completed on all students referred by school personnel or parents for a suspected health problem	
5. Completed as needed on students with a known health problem	
K. Health examinations by the doctor or nurse practitioner are:	
1. Required for all new students entering the school district K-8	

Criteria	Documentation or Comments
2. Required annually for all students competing in school athletics	
3. Reviewed by the school nurse to identify and follow-up on all health problems	
L. Screening programs are conducted as designated by the school nurse or other trained personnel	
1. Written procedures are available and being followed for: • identification of health problems • vision • hearing • scoliosis • dental • height and weight • other (list) ______ ______ ______	
2. The school nurse initiates follow-up steps to ensure further evaluation or care for all students failing screening procedures	

Criteria	Documentation or Comments
3. The teachers are notified of any preferences needed for the student to participate in the classroom	
4. Follow-up checks are made on students referred for further evaluation or care to see that such services were provided	
5. The school nurse shares the evaluation recommendations with teachers and records them on the student's health record	
6. Efforts are made to ensure that students with severe conditions receive professional care	
M. School personnel-nurse referrals and conferences:	
1. School personnel are advised and encouraged to observe each student for possible health deviations	
2. Classroom teachers are provided with information on signs to watch for in referring children for health screening and have necessary forms or written procedures to make such referrals	
3. There is an established system by which school personnel can make referrals to the school nurse	
4. The school nurse provides feedback to school personnel on referrals	

Criteria	Documentation or Comments
5. Teacher-nurse conferences are held to inform teachers of students with health problems, or list of students with health problems is given to teachers	
6. Inservice is held, as needed, to inform teachers how to handle health problems and emergencies in the school setting; i.e., epileptic seizures, diabetic coma, insulin reaction, reporting serious accidents or illness, using universal precautions	
N. Health counseling is available to public, parents, and school personnel	
1. Parents are encouraged to confer with the school nurse when a school program adjustment is needed for a student with a health problem	
2. Time and privacy are available for students to talk with the school nurse about their concerns or for the school nurse to discuss his/her screening findings with the student	
3. The school nurse can make home visits to pupils with special health problems	
4. Parents are informed of the results of health assessments and failures in screening programs either by telephone or written notice	

Criteria	Documentation or Comments
5. Parents are assisted in locating resources for care of identified health problems	
6. Students are assisted to become knowledgeable health consumers	
O. Disabled or chronically ill students are identified in the school division	
1. Parent-school nurse conferences are conducted to ascertain the student's current health status	
2. Current recommendations are obtained from the student's source of medical care	
3. Special instructions and services are provided for disabled or chronically ill students as indicated	
4. School personnel are informed of the special needs of disabled or chronically ill students if educationally appropriate	
5. The school environment is adapted to accommodate students with disabilities	
P. The school nurse is responsible for participating in the appropriate placement of students with exceptional needs	
1. The school nurse obtains health history and current health status information on students prior to determining placement	

Criteria	Documentation or Comments
2. The school nurse helps identify the relationship between the health status and the student's ability to learn	
3. The school nurse serves as a team member to identify and interpret the physical findings and health needs of the student	
4. The school nurse serves on the school team to write goals, objectives, and characteristics for the health component of the individualized educational plan (IEP) and determines health factors that are pertinent to the student's most appropriate educational placement	
Q. Communicable disease control is part of the school health services program	
1. School personnel are prepared to recognize signs of suspected communicable diseases in students	
2. School nurses report immediately to the principal and local health agency (by phone) any of the following conditions, diphtheria, rubella, measles, meningococcal disease, polio, public gathering outbreaks (e.g., food poisoning), tuberculosis	
3. School nurses report on a designated basis to the principal and the local health agency any other communicable disease	

Criteria	Documentation or Comments
4. Provisions are made for isolating students with a communicable disease until they are removed from school	
5. Students with a communicable disease do not return to school until the condition has been remedied or the student is under treatment	
6. The school health service correlates its plans for disease prevention and control with the community program	
R. A school health office or adequate work space is available in every school	
1. The nurse has available to him/her a desk with drawers, files, or cupboards for health records and supplies, and an appropriate number of chairs	
2. A telephone is available in the clinic for confidential conversations concerning student health problems	
3. First aid supplies, including ice, are readily available	
4. Privacy is possible in the school health office for conducting health counseling and health assessments	
5. One cot is available for every 400 students in the school	

Criteria	Documentation or Comments
6. The cot has a washable surface or disposable cover	
7. A locked cabinet or container is provided for storing prescription drugs	
8. A sink, separate from the bathroom facility, is located in the clinic for use in first aid and skilled care	
9. Bathroom facilities that also accommodated disabled students are available within the clinic area	
General Summary of Evaluation:	
Recommendations:	

References

Adapted From:

Task Force on Standards of School Nursing Practice, Standards of School Nursing Practice, American Nurses' Association, 2420 Pershing Road, Kansas City, Missouri, 64108, 1983.

Task Force on an Evaluation Guide for School Nursing Practice, Evaluating School Nursing Practice: A Guide for Administrators, American School Health Association, P.O. Box 708, Kent, Ohio, 44240, 1987

An Evaluation Guide for School Nursing Practice Designed for Self and Peer Review, National Association of School Nurses, Inc., P.O. Box 1300, Scarborough, Maine, 04074, 19

VIRGINIA SCHOOL HEALTH FORMS

PART I

COMMONWEALTH OF VIRGINIA

SCHOOL ENTRANCE PHYSICAL EXAMINATION AND IMMUNIZATION CERTIFICATION

HEALTH INFORMATION SECTION:(PART I to be completed by parent or guardian) Please Print or Type! Thank you.

udent's Name: ______________________ LAST ______________________ FIRST ______ MI

Complete Date of Birth:/____/____/____/ (MO DAY YR.); Sex:/____/; Number of Children in Family:/____/; State or Country of Birth: ______________

Social Security #:/__/__/__/ /__/__/ /__/__/__/__/; I.D. #: ______________

Parent or Legal Guardian: ______________________

Address: ______________________; City: ______________; Zip:/__/__/__/__/__/

Home Phone:(________)-________-________ (area code); Work Phone:(________)-________-________ (area code)

School's Name: ______________________; Grade:/____/

In case of emergency, notify: (other than parent or guardian) Please list Name, address, and Complete Phone Number (area code and number).

1) ______________________ Phone:(________) ________-________ (area code)

2) ______________________ Phone:(________) ________-________ (area code)

Birth History (weight, prematurity, any other problems at birth): ______________________

Allergies to food, medicine, insect bites/stings, or other: ______________________

/____/ Check here if you wish to discuss confidential information with school authorities.

	EQUIPMENT USED BY CHILD (please check those that apply)		CHRONIC OR RECURRING CONDITIONS (please check those that apply)
☐	Prosthesis (e.g., cane, crutch, limb)	☐	Ear Infections
☐	Brace	☐	Hard of Hearing
☐	Hearing Aids	☐	Seizures/spells
☐	Glasses	☐	Kidney Disease
☐	Helmet	☐	Sickle Cell Anemia (not trait)
☐	Wheelchair or Walker	☐	Head, spinal cord injury, or disease of central nervous system
☐	Special Shoes	☐	Eye Diseases
☐	Other (Please List!):	☐	Heart Disease
☐		☐	Asthma
☐		☐	Diabetes
☐		☐	Other (Please List!):
☐		☐	

Names of medical specialists, dentists, or special clinics caring for child: ______________________

Prescription medicines taken regularly (LIST): ______________________

Operations (dates): ______________________

Hospitalizations (dates): ______________________

er Important Information about your child: ______________________

****I give my permission for the school nurse/school to contact the examining physician to discuss any information contained on this form.

Signature of Parent/Legal Guardian: ______________________; Date (mo,day,yr):/____/____/____/

PART II

CERTIFICATION OF SCHOOL HEALTH EXAMINATION

PART II TO BE COMPLETED BY A PHYSICIAN

(Reverse to be completed by parent/guardian)

Student's Name:________________________________ (LAST / FIRST / MI); Birth Date:/____/____/____/ (MO / DAY / YR)

Height:__________; Weight:__________; Head Circumference:__________; BP:__________

Hemoglobin or Hematocrit:__________gms%; Urine Albumin:__________; Sugar:__________; Other:__________

Most recent Tuberculin Test Date:/____/____/____/ (Mo / Day / Yr); Results:__________; Hearing R__________; L__________

Vision (w/out glasses) R20/__________; L20/__________; Hearing test performed? Audiogram__________; Voice__________

Vision (with glasses) R20/__________; L20/__________; Tympanogram (if indicated): normal__________; abnormal__________

Systems Examination	Exam.	Not Exam.	Comments About Findings
General Appearance, Nutrition			
Posture, Gait			
Skin			
Head			
Eyes: External			
Fundi			
Ears: External & Canal			
Tympanic Membrane			
Nose			
Throat			
Teeth			
Neck			
Heart			
Lungs			
Abdomen			
Genitalia (Tanner Stage)			
Bones, joints, muscles			
Neurological			
Other:			
Est. of developmental level			
Behavioral Observations:			
Cooperation			
Emotional tone			
Activity level			

Summary of abnormal conditions which may require; (a) Educational evaluation, (b) Environmental adjustment, or (c) Activities to be limited:__________

Referrals made:__________

Physician (print):__________; Signature:__________; Date/____/____/____/

Address:__________; Phone(______) ______-______ (area code)

MCH-213C,Rev.10/91

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PART III

CERTIFICATION OF IMMUNIZATION

Part III to be Completed by a Physician or Health Department Official!

Student's Name: ____________________ DOB: /__/__/ /__/__/ /__/__/
LAST FIRST MI MO DAY YR

dent's S.S. #: ____________________; I.D #: ____________________

Parent/Guardian: ____________________

IMMUNIZATIONS	RECORD COMPLETE DATES (month,day,year) OF VACCINE DOSES ADMINISTERED				
Diphtheria/Tetanus/Pertussis (DTP)	/__/__/__/	/__/__/__/	/__/__/__/	/__/__/__/	/__/__/__/
Diphtheria/Tetanus (DT or Adult Td)	/__/__/__/	/__/__/__/	/__/__/__/	/__/__/__/	/__/__/__/
Poliomyelitis (OPV or eIPV)	/__/__/__/	/__/__/__/	/__/__/__/	/__/__/__/	/__/__/__/
Measles (Rubeola)	/__/__/__/	/__/__/__/	Serological Confirmation of Measles Immunity	/__/__/__/	
Rubella	/__/__/__/	/__/__/__/	Serological Confirmation of Rubella Immunity	/__/__/__/	
Mumps	/__/__/__/	/__/__/__/	Child Entered School Before 08/01/81	/__/__/__/	
Measles, Mumps, Rubella (MMR)	/__/__/__/	/__/__/__/			
Hepatitis B Vaccine	/__/__/__/	/__/__/__/	/__/__/__/	Other:______	/__/__/__/

Haemophilus influenzae Type b (Hib Conjugate): PLEASE COMPLETE THE APPROPRIATE SECTION BELOW.

☐ Has received complete series of Hib vaccine in accordance with current recommendations of the AMERICAN ACADEMY OF PEDIATRICS OR THE U.S. PUBLIC HEALTH SERVICE.

☐ Has received the AGE-APPROPRIATE doses of Hib vaccine as recommended by the AMERICAN ACADEMY OF PEDIATRICS OR THE U.S. PUBLIC HEALTH SERVICE, the series will be completed on (RECORD COMPLETE DATE (month,day,year):

Series Completion Date: /__/__/__/
MO DAY YR

☐ Hib vaccine is not indicated because this child has had Hib disease at 24 months of age or older.

☐ Being over 30 months of age, this child is not required by law to have proof of immunization against Hib.

MEDICAL EXEMPTION: DTP ☐; Td ☐; OPV ☐; Hib ☐; Measles ☐; Mumps ☐; Rubella ☐.

As specified in 22.1-271.2,c(ii) of the Code of Virginia, I certify that administration of the vaccine(s) designated above would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify): ____________________

____

This contraindication is permanent ☐, or temporary ☐ and expected to preclude immunization until ____________________

Signature of PHYSICIAN or HEALTH DEPT. OFFICIAL: ____________________ Date: /__/__/__/

RELIGIOUS EXEMPTION: The Code of Virginia allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school for the first time after July 1, 1983, must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1) which may be obtained at any local health department, school division superintendent's office or local department of Social Services. Ref. Code 22.1-271.2, C(i), CODE OF VIRGINIA

*I certify that this student has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this student has a plan for the completion of his/her requirements within the next 90 days (conditional enrollment).

Signature of Physician or Health Dept. Official: ____________________; Date(mo,day,yr): /__/__/__/

I certify that this student is ADEQUATELY IMMUNIZED in accordance with the MINIMUM requirements for attending school prescribed by the State Board of Health on the reverse side of this form.

Signature of Physician or Health Dept. Official: ____________________; Date(mo,day,yr): /__/__/__/

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PART IV

MINIMUM IMMUNIZATIONS REQUIRED OF NEW STUDENTS BY THE STATE BOARD OF HEALTH FOR *SCHOOL ATTENDANCE

DTP: THREE (3) doses of DTP with one (1) of the three (3) administered after the fourth birthday. If any of these doses must be administered on or after the seventh birthday, ADULT Td should be used instead of DTP.

OPV: THREE (3) doses of trivalent OPV with one of the three administered after the fourth birthday or three (3) doses of eIPV with one of the three administered after the fourth birthday.

MEASLES: TWO (2) doses of live virus measles (rubeola) vaccine, one dose given at 12 months of age or older and a second dose administered prior to entering KINDERGARTEN or first grade, whichever occurs first, effective JULY 1, 1991.

RUBELLA: ONE (1) dose of rubella vaccine received at 12 months of age or older.

MUMPS: ONE (1) dose of mumps vaccine received at 12 months of age or older for students entering school on or after AUGUST 1, 1981.

*SCHOOL DEFINITION: a) Any public school from kindergarten through grade 12 operated under the authority of any locality within this Commonwealth; b) Any private or parochial school that offers instruction at any level or grade from kindergarten through grade 12; c) Any private or parochial nursery school or preschool, or any private or parochial child care center licensed by this Commonwealth; and d) Any preschool handicapped classes or Head Start classes operated by the school divisions within this Commonwealth.

If there are questions please call your local health department.

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Form HPE-h12 12/83

SCHOOL ENTRANCE HEALTH INFORMATION FORM

Name: ______________________________ Birthdate: Mo. ____ Day ____ Yr. ____
Last First Middle Name
Sex: Male___ Female___ Race: _____ Child's Social Security Number __________
Parent or Guardian ______________________________ Work Phone: __________
Last First Middle Initial Home Phone: __________
Home Address: ______________________________ Zip: __________
Person to call in case of an emergency if parent/guardian is not available:
Name: ______________________________ Phone: __________

Please provide information relative to the general health of your child entering school for the first time and return to principal within 15 days.

ACUTE OR CHRONIC ILLNESS

__ Yes __ No Asthma
__ Yes __ No Cerebral Palsy
__ Yes __ No Cystic Fibrosis
__ Yes __ No Diabetic (Insulin dependent)
__ Yes __ No Epilepsy
__ Yes __ No Frequent colds
__ Yes __ No Frequent sore throat
__ Yes __ No Hyperthyroidism
__ Yes __ No Hypothyroidism
__ Yes __ No Allergies other than those related to food/drugs: if yes, describe

__ Yes __ No Cancer: if yes, describe

__ Yes __ No Heart disease: if yes, describe

ACCIDENTS

Has your child had any of the following? If yes, describe

__ Yes __ No Burns requiring treatment

__ Yes __ No Bumps to head requiring treatment

__ Yes __ No Fractures

__ Yes __ No Lacerations or cuts requiring stitches or tetanus booster

__ Yes __ No Near drowning

__ Yes __ No Poisoning

__ Yes __ No Serious falls

MEDICATIONS

Is your child using any medicines? If yes, describe

__ Yes __ No Prescription drugs: identify drug and condition requiring drug

__ Yes __ No Over-the-counter drugs (nonprescription): identify drug and reason for use

__ Yes __ No Drug allergies: identify drug and reaction

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NUTRITION

__ Yes __ No Abdominal pain
__ Yes __ No Underweight or overweight for age
__ Yes __ No Allergies related to foods: identify food and reaction
__ Yes __ No Problems with elimination (bowel movement and/or urination)

OPERATIONS

__ Yes __ No Appendectomy
__ Yes __ No Hernia
__ Yes __ No Tonsillectomy
Other ____________________

HANDICAPPING CONDITION

__ Yes __ No Scoliosis
__ Yes __ No Spina bifida
Other ____________________

ORTHOPEDIC DEVICES

__ Yes __ No Wheelchair
__ Yes __ No Special shoes
__ Yes __ No Crutches
__ Yes __ No Braces
__ Yes __ No Helmet

HEARING

__ Yes __ No Frequent ear aches
__ Yes __ No Running ear
__ Yes __ No Hard of hearing
__ Yes __ No Uses hearing aid

COMMUNICATION

__ Yes __ No Speech understandable
__ Yes __ No Stutters/stammers
__ Yes __ No Lisps

DENTAL

__ Yes __ No Cavities
__ Yes __ No Cleft lip or palate
__ Yes __ No Gum disease
__ Yes __ No Lost some or all baby teeth
__ Yes __ No Permanent teeth appearing
__ Yes __ No Wears dental braces

MENTAL AND EMOTIONAL

__ Yes __ No Bullies others
__ Yes __ No Cries often
__ Yes __ No Lethargic (slow/lazy)
__ Yes __ No Short attention span
__ Yes __ No Toilet trained
__ Yes __ No Very sensitive
__ Yes __ No Very shy
__ Yes __ No Generally happy

BLOOD DISORDERS

__ Yes __ No Anemia
__ Yes __ No Leukemia
__ Yes __ No Hemophilia
__ Yes __ No Sickle Cell Anemia

HABITS

__ Yes __ No Sleeps/Rests well
__ Yes __ No Exercises daily
__ Yes __ No Eats well
__ Yes __ No Bathes regularly
__ Yes __ No Brushes teeth regularly

VISION

__ Yes __ No Wears glasses
__ Yes __ No Rubs eyes frequently
__ Yes __ No Squints
__ Yes __ No Color blind

SKIN AND HAIR

__ Yes __ No Visible scars
__ Yes __ No Hives
__ Yes __ No Scabies
__ Yes __ No Body lice
__ Yes __ No Head lice

Were there any prenatal or birth complications which affected the child?

Please indicate any other health conditions(s) your child has that is not covered on form.

Signed: ____________________
(Signature by parent/guardian)
Date: ____________________

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VIRGINIA HIGH SCHOOL LEAGUE, INC.

Form 2

1642 State Farm Blvd., Charlottesville, Virginia 22901

Athletic Participation Parental Consent Physical Examination Form

eparate examination and certification required for each school year – June 1 of the current year through June 30 of the succeeding year. File in the Office of the Principal

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PART I – ATHLETIC PARTICIPATION

(To be filled in and signed by the student)

For School

Year ________

Male ________

Female ________

Name ______________________________ Social Security # ____________
(Last) (First) (Middle Initial)

Home address ______________________________

City Zip code ______________________________

Home address of parents ______________________________

City Zip code ______________________________

Date of birth ______________ Place of birth ______________

This is my ____ semester in ______________ High School, and my ____ semester since first entering the ninth grade. Last semester I attended ______________ School and passed ____ subjects, and I am taking ____ credit subjects this semester. I have read the condensed individual eligibility rules and the risk statement of the Virginia High School League, Inc. that appear below and believe I am eligible to represent my present high school in athletics.

INDIVIDUAL ELIGIBILITY RULES

Attention Athlete and Cheerleader! To be eligible to represent your school in any VHSL, Inc., interscholastic athletic contest you –

- must be a regular bona fide student in good standing of the school you represent.
- must have been promoted to the ninth grade (eighth-grade students may be eligible for junior-varsity competition).
- must have enrolled not later than the fifteenth day of the current semester.
- must have passed at least five credit subjects the immediately preceding year and must be currently taking not fewer than five credit subjects for participation during the first semester.
- must have passed at least five credit subjects the previous semester and must be currently taking not fewer than five credit subjects for participation during the second semester.
- must not have reached your nineteenth birthday on or before the first day of October of the current school year.
- must have been in residence at your present high school, or at a junior high school from which your high school receives its students, during the entire semester immediately preceding the one in which you desire to participate.
    - unless you are transferring from a public or nonpublic school with a corresponding move on the part of your parents into the area served by your present school.
    - unless you are transferring to the high school serving the district in which your parents reside upon completion of the highest grade level offered by the intermediate school, middle school, junior high school, or nonpublic school from which you are transferring.
    - unless you are entering the ninth grade for the first time.
    - unless your former school was discontinued or consolidated and you were required to transfer to your present school.
    - unless you are legally adopted, are a foreign exchange student, are under the guidance of an orphanage, the State Department of Welfare, or State Department of Corrections, or are required to change residence by court order.
    - unless you are transferring from a nonmember high school to a member school of the attendance area of your parents or guardians, provided you have not participated during the current school year at the school from which you transferred in the sport in which you wish to participate at your current school.
- must not, after entering the ninth grade for the first time, have been enrolled in or been eligible for enrollment in high school more than eight consecutive semesters.
- must have submitted to your principal before practicing, trying out or becoming a member of any school athletic team an Athletic Participation/Parental Consent/Physical Examination Form, completely filled in and properly signed, attesting that you have been examined during this school year and found to be physically fit for athletic competition and that your parents consent to your participation. Students selected to be cheerleaders shall complete this form and submit it to their principal.
- *must be an amateur as defined by the Virginia High School League, Inc.,: "An amateur is an athlete who engages in VHSL, Inc. athletics solely for the educational, physical, mental and social benefits he derives therefrom and to whom VHSL, Inc., athletics are nothing more than an avocation."**
- *must not have received in recognition of your ability as a high school athlete any award not presented or approved by your school or the League.**
- *must not, while a member of a school's team in any sport, become a member of any other organized team or participate in a non VHSL, Inc., sanctioned meet or tournament in the same sport during the school's sports season.**
- *must not have participated in any all-star contest between teams whose players are selected from more than one high school.**
- *must not have been a member of a college team in the sport in which you wish to participate.**

**Italicized item does not apply to cheerleaders.*

Eligibility to participate in interscholastic athletics is a privilege you earn by meeting not only the above-listed minimum standards, but also all other standards set by your League, district, and school. If you have any question regarding your eligibility or are in doubt about the effect an activity might have on your eligibility, **check with your principal or athletic director; they are aware of the various interpretations and exceptions provided under League rules.** Meeting the intent and spirit of League standards will prevent you, your team, school, and community from being penalized.

LOCAL SCHOOL DIVISIONS AND VHSL DISTRICTS MAY REQUIRE ADDITIONAL STANDARDS TO THOSE LISTED ABOVE.

____
Student Signature

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PART II – MEDICAL HISTORY

This form should be completed by parent and athlete prior to time of physical examination and should be taken with physical examination form for review by the physician during the examination.

	YES	NO
1. Have you ever had any of the following?		
heart murmur	______	______
high blood pressure	______	______
other heart problems	______	______
broken bones	______	______
weak joints - ankles, knees	______	______
concussion	______	______
operation	______	______
seizures or epilepsy	______	______
2. Have you ever fainted or passed out?	______	______
3. Have you ever been knocked out?	______	______
4. Have you ever been hospitalized?	______	______
5. Have you ever had to stop running 1/4 to 1/2 mile for chest pain, or shortness of breath?	______	______
6. Have you ever had significant allergies?		
hay fever	______	______
asthma	______	______
bee stings	______	______
poison ivy	______	______
foods	______	______
medicine	______	______
7. Do you take any medicine regularly?	______	______
8. Have you had any illnesses lasting a week or more such as mononucleosis, etc.?	______	______
9. Have you had any blood disorders, including sickle cell trait, anemia, etc.?	______	______
10. Has any family member had a heart attack, heart problems or other sudden death before age 50?	______	______
11. Do you wear contact lenses, eye glasses or dental appliance?	______	______
12. Do you have any missing or non-functioning organs such as testes, eye, kidney, etc.?	______	______
13. Menstrual History:		
(a) Have you begun menses yet?	______	______
(b) If so, what age?	______	______
(c) Do you have any menstrual problems?	______	______
14. DATE OF LAST TETANUS IMMUNIZATION	______	______

Please explain any yes answers from above ______________________________

____

____

____

____

____

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PART III – PHYSICAL EXAMINATION

(To be completed and signed by examining physician)

NAME ____________________ SCHOOL ____________________

HEIGHT ________ WEIGHT ________ SEX ________ AGE ________ GRADE ________

*Tanner Stage or Maturation Index ____________
*Percent Body Fat ____________

*Vision Corrected (L) ___ (R) ___ Both ___
Uncorrected (L) ___ (R) ___ Both ___
*Audiogram ____________

Eyes ____________
Ears ____________
Nose ____________
Throat ____________
Teeth ____________
Skin ____________
Lymphatics ____________
Heart ____________
Lungs ____________
Abdomen ____________
Genitalia/hernia ____________
Peripheral pulses ____________

BP ________
*Pulse (rest) ________
(Exercise) ________
(Recovery) ________

Cervical spine neck ____________
Back ____________
Shoulders ____________
Arm/elbow/wrist/hand ____________
Knees/hips ____________
Ankles/feet ____________

Lab:

*Urine ____________
*Hemoglobin or HCT ____________
and/or Fe Stores ____________

***WHEN MEDICALLY INDICATED**

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

1. Full participation ____________________
2. Limited or no participation ____________________
   Reason ____________________
3. Requires additional evaluation ____________________
   ____
4. Comments and explanation ____________________
   ____
   ____
   ____

Physician signature ____________________ ,M.D.* Date ____________

Physician name (print) ____________________

Address ____________________

City/Zip code ____________________

Telephone ____________________

*Doctor of Medicine or Doctor of Osteopathy

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PART IV – ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT

(To be completed and signed by parent/guardian)

I give permission for ______________________ (name of child/ward) to participate in any of the following sports that are **not** crossed out: baseball, basketball, cheerleading, cross country, field hockey, football, golf, gymnastics, lacros soccer, softball, swimming, tennis, track, volleyball, wrestling, other (identify sports) ______________________

I have reviewed the individual eligibility rules and I am aware that with the participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying a higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts, or some other means. He/She has student accident insurance available through the school ( ); has football insurance coverage available through the school ( ); is insured by our family policy with ______________________ (name of company) Insurance ( ).

I am aware that participation in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team.

I also give my consent and approval for my child/award to receive a physical examination, as required in Part III, Physical Examination, of this form, by ______________________ M.D., or by a qualified, registered physician as recommended by the named student's school administration.

Signature of parent (guardian) ______________________ Date ____________

PART V – EMERGENCY PERMISSION FORM*

(To be completed and signed by parent/guardian)

STUDENT'S NAME ______________________ GRADE ________ AGE ______

HIGH SCHOOL ______________________

Please list any significant health problems that might be significant to a physician evaluating your child in case of an emergency. ______________________

____

____

Please list any allergies to medications, etc. ______________________

____

____

Is student presently taking medication? ________ If so, what type? ______________________

Does student wear contact lenses? ________ Please list date of last tetanus shot. ______________________

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to the physicians selected by the coaches and staff of ______________________ High School to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the person named above.

Signature of parent or guardian ______________________

Relationship to student ______________________

Daytime phone number (where to reach you in emergency) ______________________

Evening time phone number (where to reach you in emergency) ______________________

***Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed.**

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COMMONWEALTH OF VIRGINIA
CERTIFICATE OF RELIGIOUS EXEMPTION

Name ____________________ Birth Date ____________

Student I.D. Number ____________________

The administration of immunizing agents conflicts with the above named student's/my religious tenets or practices. I understand, that in the occurrence of an outbreak, potential epidemic or epidemic of a vaccine-preventable disease in my/my child's school, the State Health Commissioner may order my/my child's exclusion from school for my/my child's own protection, until the danger has passed.

____________________ ____________
Signature of parent/guardian/student Date

I hereby affirm that this affidavit was signed in my presence on

this ____________ day of ____________.

Notary Public Seal

COMMONWEALTH OF VIRGINIA -
STUDENT IMMUNIZATION STATUS REPORT

Please Type or Print All Information!

FACILITY: ____________________

MAILING ADDRESS: ____________________

CITY: ____________________ ZIP: ________

LOCATION: STREET: ____________________

COUNTY: ____________________ CITY: ____________________

PERSON PREPARING REPORT (PRINT): ____________________ TITLE: ________

SIGNATURE: ____________________ DATE: ________ PHONE: ________

TYPE OF FACILITY REPORTING!

1)Please check one of the following:

PUBLIC SCHOOL/_____/; PRIVATE SCHOOL/_____/; PAROCHIAL SCHOOL/_____/; HEAD START/_____/; CHILD CARE CENTER/_____/

INSTRUCTIONS!

1) Please complete this report using information in each student's school medical record.

2) Please refer to the back section of this form for the MINIMUM IMMUNIZATIONS REQUIRED BY THE CODE OF VIRGINIA.

3) ALL SCHOOLS: Please submit to the ADDRESS BELOW by __________.

VIRGINIA DEPARTMENT OF HEALTH
BUREAU OF IMMUNIZATION
1500 E. MAIN ST., SUITE 120
RICHMOND, VIRGINIA 23219
PHONE # (804)786-6246

COMPLETE THE SECTION(S) APPLICABLE TO YOUR FACILITY

Please note in each section, numbers in columns (b) through (f) should add together to equal the total number of students in column (a).

SECTION I
CHILD CARE CENTERS, HEAD STARTS OR PRESCHOOLS

(a) Number of Students Enrolled	(b) Number Adequately Immunized	(c) Number of Medical Exemptions	(d) Number of Religious Exemptions	(e) Number of Conditionally Enrolled	(f) Number Without Records

SECTION II
KINDERGARTEN OR FIRST GRADE IF THERE IS NO KINDERGARTEN(PUBLIC, PRIVATE, PAROCHIAL)

(a) Number of Students Enrolled	(b) Number Adequately Immunized	(c) Number of Medical Exemptions	(d) Number of Religious Exemptions	(e) Number Conditionally Enrolled	(f) Number Without Records

Form SIS-2, Rev. 10/91

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MINIMUM IMMUNIZATIONS REQUIRED OF NEW STUDENTS BY THE STATE BOARD OF HEALTH FOR SCHOOL ATTENDANCE

For More Information Please Refer to the Code of Virginia 22.1-271.2 Immunization Requirements and Section 3.00 of the Rules and Regulations for the Immunization of School Children.

DTP: THREE (3) doses of DTP with one (1) of the three (3) administered after the fourth birthday. If any of these doses must be administered on or after the seventh birthday, ADULT Td vaccine should be used instead of DTP.

OPV: THREE (3) doses of trivalent OPV or THREE (3) doses eIPV with one of the three administered after the fourth birthday.

MEASLES: TWO (2) doses of live virus measles (rubeola) vaccine, one (1) dose given at 12 months of age or older and a second dose administered prior to entering KINDERGARTEN or first grade, whichever occurs first.

RUBELLA: ONE (1) dose of rubella vaccine received at 12 months of age or older.

MUMPS: ONE (1) dose of mumps vaccine received at 12 months of age or older for students entering school on or after August 1, 1981.

CONDITIONAL ENROLLMENT: In order for a student to be CONDITIONALLY ENROLLED, the student must have proof of having received at least one (1) dose of each of the required immunizations (DTP, OPV, MEASLES, MUMPS, and RUBELLA) and have a schedule on file to receive the remainder of the required doses within 90 DAYS.

RELIGIOUS EXEMPTIONS: The student or his parent or guardian submits a CERTIFICATE OF RELIGIOUS EXEMPTION (FORM CRE-1), to the admitting official of the school to which the student is seeking admission. Form CRE-1 is an affidavit stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. The CRE-1 must be signed by a NOTARY PUBLIC AND STAMPED WITH THE NOTARY'S SEAL.

MEDICAL EXEMPTIONS: The school must have written certification from a physician or a local health department on FORM MCH213B that one or more of the required immunizations may be detrimental to the student's health. Such certification of medical exemption shall specify the nature and probable duration of the medical condition or circumstance that contraindicates immunization.

IF THERE ARE QUESTIONS REGARDING IMMUNIZATIONS PLEASE CALL YOUR LOCAL HEALTH DEPARTMENT OR THE BUREAU OF IMMUNIZATION @ (804) 786-6246

Form SIS-2, Rev.10/91

COMMONWEALTH OF VIRGINIA
Summary of Screening of Vision and Hearing
Report to Principal

School: ______________________ Year: ______________________

Person Preparing Data: ______________________ Signature: ______________________
Principal or Designee

Check Level: ___ Elementary (Grade 3) Total student population ________
___ Secondary (Grade 7) Total student population ________
___ Secondary (Grade 10) Total student population ________

SCREENING	# SCREENED	NUMBER REFERRED FOR SUSPECTED DEFECT			NO REPORT FOLLOWING REFERRAL			NUMBER OF THOSE REFERRED THAT WERE SEEN BY HEALTH CARE PROVIDERS			NUMBER OF THOSE SEEN BY HEALTH CARE PROVIDER WITH DIAGNOSED DEFECTS, (Includes those seen once as well as those receiving ongoing active care)		
		BOY	GIRL	TOTAL	BOY	GIRL	TOTAL	BOY	GIRL	TOTAL	BOY	GIRL	TOTAL
VISION													
HEARING													

423

* Screener should submit separate summaries for each designated grade level.

Form to be submitted to Superintendent or Designee.

LF.011 422

403

SUMMARY OF SCREENING OF VISION AND HEARING

School: Self explanatory

Year: School year example: 1991-92

Person Preparing Data: The name and title of person who is collecting data. Example: Mary Smith, RN, or Julia Brown, Teacher.

Signature of Principal: Self explanatory

Check Level: Check appropriate grade level

Total Student Population: Total number of students in grade level checked above.

Number Screened: Total number screened

Number Referred for Suspected Defect: (reported by sex and total) This is the number of suspected defects out of the total number screened.

No Report Following Referral: (reported by sex and total) This equals all those referred that no report or follow-up has been done.

Number of Those Referred That Were Seen By Health Care Providers: This reflects those who were seen by an ophthalmologist, physician, optometrist or other health care provider for the suspected defect.

Number of Those Seen By Health Care Provider With Diagnosed Defects: (reported by sex) This includes those seen once as well as those who may continue to receive ongoing active care. This number reflects those with corrections even though it may take several visits or years to complete care. Once the child is under care for condition the primary goal has been met.

Submit to Superintendent or Designee for compilation of the local school division's cumulative report.

L.F..011
3/92

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COMMONWEALTH OF VIRGINIA
Summary of Screening of Vision and Hearing
School Division Report

School Division: ______________________________ **Year:** ____________________

Person Preparing Data: ________________________

Check Level: ___ **Elementary** (Grade 3) **Total student population** _________
___ **Secondary** (Grade 7) **Total student population** _________
___ **Secondary** (Grade 10) **Total student population** _________

SCREENING	# SCREENED	NUMBER REFERRED FOR SUSPECTED DEFECT			NO REPORT FOLLOWING REFERRAL			NUMBER OF THOSE REFERRED THAT WERE SEEN BY HEALTH CARE PROVIDERS			NUMBER OF THOSE SEEN BY HEALTH CARE PROVIDER WITH DIAGNOSED DEFECTS, (Includes those seen once as well as those receiving ongoing active care)		
		BOY	GIRL	TOTAL	BOY	GIRL	TOTAL	BOY	GIRL	TOTAL	BOY	GIRL	TOTAL
VISION													
HEARING													

Filed locally for administrative purposes.

LF.010

3/92

COMMOMWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
SCOLIOSIS REPORT

SCHOOL DIVISION: ______________________ DATE ______________

NAME OF SCHOOL: ______________________

PERSON COMPLETING FORM: ______________________

TITLE OR POSITION: ______________________

RESULTS OF MEDICAL EXAMINATION OF REFERRED STUDENTS FROM THIS YEAR'S SCREENING PROGRAM.

GRADE LEVEL AND SEX	NUMBER SCREENED	NUMBER SCREENED WITH SUSPECTED FINDINGS AND REFERRED THIS SCREENING	NUMBER OF RESPONSE TO REFERRAL	NUMBER SEEN BY PHYSICIAN AND REPORT INDICATES NO SIGNIFICANT FINDINGS	RESULTS OF MEDICAL EXAMINATION OF REFERRED STUDENTS							PREVIOUSLY DIAGNOSED AS SCOLIOSIS AND UNDER TREATMENT AT THIS TIME. IDENTIFY TYPE OF TREATMENT ON BACK OF FORM.	NO RESPONSE TO REFERRAL
					NUMBER SCOLIOSIS CASES DIAGNOSED	NO TREATMENT PRESCRIBED	REVIEW AS REQUESTED BY PHYSICIAN	EXERCISE AND/OR PT	BRACING	SURGERY	OTHER CONDITIONS DIAGNOSED (LIST ON BACK)		
1	2	3	4	5	6	7	8	9	10	11	12	13	14
5M													
5F													
6M													
6F													
7M													
7F													
8M													
8F													
9M													
9F													
TOTAL													

Numbers in columns 7, 8, 9, 10, and 11 should equal number in column 6.
Numbers in columns 5, 6, and 12 should equal the number in column 4.

COLUMN HEADING DEFINITIONS

Column 2 - The number in this column does not include those students having had surgery, braces, or undergoing treatment at this time. These should be included in column 13.

Column 3 - The number in this column are students with suspected findings and referred to a physician during this year. A student may be counted who was referred last year and did not receive treatment and was screened again this year and referred again. This includes those students whose physicians recommended no treatment last year but requested continued monitoring.

Column 6 - The number in this column includes all the students diagnosed as having scoliosis after being referred from column 3.

Column 12 - The number in this column includes all the students who have postural conditions and diagnosed as a condition other than scoliosis by the physician. List these conditions below:

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

Column 13 - No student in this column should have been included in any other column on this report.

____________________ ____________________
____________________ ____________________
____________________ ____________________

Please compile and return to designated person within local school division.

Disposition: To be maintained and filed locally.

NUTRITION WORKSHEET AND REFERRAL FORM

CHILD'S NAME ______________________ DATE ____________
DATE OF BIRTH ____________ AGENCY/SCHOOL/CLINIC ____________
AGE ______________________ PHONE NUMBER ______________

DIRECTIONS: Review items, fill in the blanks and check concerns. Describe nutrition related problems under COMMENTS. When a referral is made, file a copy of this form in the child's record and send the original to the nutritionist.

MEDICAL: Diagnosis ______________________

Vitamin/Mineral Supplements ______________________

Medications ______________________

Dental Concerns ______________________

Elimination Problems ______________________

Muscle Tone ______________________

ANTHROPOMETRIC: Weight ____________ Height ____________
Weight/Age ____________% Height/Age ____________%
Weight/Height ____________%

BIOCHEMICAL: Lab data of concern (when available) ____________

____

DIETARY/FEEDING: Check areas of concern and specify needs whenever possible.

Feeding Skills: ☐ Self feeding ☐ Needs assistance
☐ Drinks from a bottle ☐ Drinks from a cup
☐ Cup drinking w/assistance

☐ Feeding Abnormality (delayed skills; problems chewing, swallowing, etc.; special feeding equipment or positioning, etc.) ______________________

☐ Special Dietary Need (extra calories, fluid or fiber, calorie restriction, etc.) or Therapeutic Diet (diabetic diet, PKU diet, etc.) ______________________

☐ Tube Feeding ______________________

☐ Refuses to eat certain foods/possible deficiency ____________

____

☐ Limited food supply due to socioeconomic status ____________

____

☐ Parental Concern(s) ______________________

____

☐ Other ______________________

____

NUTRITION WORKSHEET AND REFERRAL FORM

NUTRITION/FOOD ASSISTANCE PROGRAMS: Check program(s) in which t child/family is enrolled or receiving services:

- ☐ WIC
- ☐ Food Stamps
- ☐ School Lunch Program
- ☐ School Breakfast Program
- ☐ Head Start
- ☐ Other ______________

COMMENTS AND ADDITIONAL INFORMATION:

Signature of the Screener____

Title of the Screener____

Nutrition Referral Sent to____

Phone Number of the Nutritionist____

Referral Date ________________________________

REFERRAL, DISPOSITION AND RETENTION:
The original form is to be completed by a health professional, therapist or teacher providing the nutrition screening. After the screener has signed the form and completed the screening process, the original colored form should be sent to the nutritionist and filed in the child's medical chart. A copy should be kept in the child's health record in the agency or clinic where the child was screened.

Nutrition Related Problems
(supplement for Nutrition Worksheet and Referral form)

MEDICAL: .Primary Diagnosis

.Medical or dental problems associated with diagnostic conditions which may interfere with the nutritional status or dietary habits of the child (examples):

constipation
developmental delays
dehydration
food allergies or intolerance
drug/nutrient interactions
gum disease, gingivitis
hypertension
malabsorption
urinary tract infection
hypotonia, hypertonia

ANTHROPOMETRIC: .Documented inappropriate weight gain or growth pattern.

-weight/height > 90th percentile
-weight/height < 10th percentile
-height/age < 10th percentile
-flat growth curve over a 12 month period
-growth regression pattern on the growth chart

.Special considerations when interpreting growth charts in certain handicapping conditions:

DOWN'S SYNDROME:

-substandard height for all ages which increases susceptibility

-deficient growth velocity most apparent during first 2 years of life; in later years growth velocity appears normal

CEREBRAL PALSY:

-slow growth in height as well as delayed bone and skeletal development associated with slow neuromotor development

-weight varies depending on the degree and type of C.P.

CYSTIC FIBROSIS:

-frequently substandard weight and height

-nutritional goal should be to maintain weight and height/age 25th percentile

-some studies have shown a correlation between the degree of pulmonary involvement and the degree of weight and height retardation

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SPINA BIFIDA:

-short stature

-weight/age often unreliable in screening for weight problems; weight/height is more reliable

-susceptibility to obesity

BIOCHEMICAL: .abnormal levels of laboratory tests:

	Age	Hct.	Hgb.
	6-23 mo.	< 34%	< 11gm.
	2-5 yr.	< 34%	< 11gm.
	6-14 yr.	< 37%	< 12gm.
female	15+ yr.	< 37%	< 12gm.
male	15+ yr.	< 40%	< 13gm.

DIETARY/FEEDING: .Feeding Abnormality

-abnormal mealtime behavior

-delayed feeding skills

-frequent choking, gagging, vomiting or drooling

-oral motor disfunction or mechanical feeding problems

.Special diet order as prescribed by a physician

.Enteral Feeding

.Diet lacking in one or more food groups

.Low intake of nutrients

.Poor food supply due to socioeconomic status

.Pica

.Inadequate fluid intake

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CUMULATIVE HEALTH RECORD

ANNUAL PHYSICAL INSPECTION

FULL NAME ______________________________ DATE OF BIRTH ____________
LAST FIRST MIDDLE

SEX ____ CHECK DISEASES HAD (✓) RHEUMATIC FEVER ( ) DIPHTHERIA ( )

SCARLET FEVER ( ) SMALL POX ( ) PERTUSSIS (WHOOPING COUGH) ( ) CHICKEN POX ( ) MUMPS ( ) MEASELS ( )

CODE: NO DEFECT ○ DEFECT × DEFECT CORRECTED ⊗ DEFECT BEING TREATED Ⓣ

YEAR	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19
HEIGHT															
WEIGHT (Circle if under or overweight)															
VISION RIGHT															
VISION LEFT															
HEARING RIGHT															
HEARING LEFT															
TEETH															
THROAT															
SCOLIOSIS (Put S in black if Scoliosis is suspected. Code as above.)															
POSTURE															
SPEECH															
PARENTS/GUARDIAN NOTIFIED ( )															
EXAM (BY PHYSICIAN) ( )*															
EXAM (BY DENTIST) ( )*															

IMMUNIZATION HISTORY *

Dose	DPT MO DAY YR	POLIO MO DAY YR	MEASLES MO DAY YR	RUBELLA MO DAY YR	MUMPS MO DAY YR	Td (ADULT) MO DAY YR
1st						
2nd						
3rd	433					
4th						
5th						

REMARKS

*[Note: The Cumulative Health Record needs to be adapted to meet MCH-213C immunization requirements]

(*When no medical examination is given, leave space blank)

19		Physician Dentist
19		Physician Dentist
19		Physician Dentist
19		Physician Dentist
19		Physician Dentist
19		Physician Dentist
19		Physician Dentist

474

MEDICAL AND DENTAL EXAMINATIONS

YEAR	RECOMMENDATIONS BY PHYSICIAN OR DENTIST	NAME OF PHYSICIAN OR DENTIST
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist

Form No. HPE-h-9—125M 4 83

VIRGINIA PHYSICAL INSPECTION OF STUDENTS

NOTICE SENT BY TEACHER OR NURSE TO PARENTS

SEX

Name of Student: ______________________ M F Date ______________

Parent or Guardian ______________________ Address ______________________

Family Physician ______________________

You are advised to consult your child's physician and/or dentist.

Our school inspection indicates that special attention may be needed for the items checked below:

Weight
Vision
Hearing
Teeth
Throat

Scoliosis
Posture
Speech
Skin
Other:

Immunization
Diptheria-Pertussis-Tetanus (DPT)
Measles
Polio
Rubella (German Measles)
Mumps

When an examination is made, please have the professional examiner insert findings and recommendations on the reverse side of this form for return to the school.

Teacher or Nurse ______________________

School ______________________

(OVER)

Form No. HPE-h-9—125M 4/83

HEALTH SERVICES

TO: Professional Examiner: Completed form will be given to parent for return to teacher or nurse.

TO: Clinic: Completed form will be returned to teacher or nurse.

Findings and Recommendations:

DEFECT(S): Corrected ______________________ **Being Treated** ______________________

Signed: ______________________ **Professional Degree** ______________________

Date: ______________________

Teacher/Nurse — Note corrections and recommendations and record on cumulative record.

Va. Department of Health

Va. Department of Education

APPENDICES

Appendix A

SENATE DOCUMENT NO. 22, 1987

THE HEALTH NEEDS OF SCHOOL AGE CHILDREN

Recommendations

The Secretary's Task Force on the Health Needs of School-Age Children was an outgrowth of Senate Joint Resolution Number 76 which requested the Secretary of Human Resources to study the health needs of school-age children.

Based on its research and formal discussions, the task force recommends the establishment of the following recommendations to strengthen and coordinate school health service to meet effectively the health needs of school-age children in Virginia.

Specifically, the task force calls for:

1. The number of nurses providing school health services should be increased to allow for at least one nurse in every school or a ratio of one nurse per 1,000 students.
2. Minimum standards for school health services in Virginia should be developed jointly by the Departments of Education and Health.
3. The Departments of Education and Health should establish a nursing position within the State Department of Education to supervise and coordinate the provision of school health services in the Commonwealth.
4. The Department of Education should mandate family life education curriculum in grades K-12 with an emphasis on promoting parental involvement and the fostering of positive family living skills in all public schools in the Commonwealth.
5. The Departments of Health and Education along with the Virginia Dental Association should work together on a state and local level to coordinate dental care resources and to increase dental screenings and educational programs.
6. A formal memorandum of agreement should be developed between the Secretary of Human Resources and the Secretary of Education to address overlapping concerns related to the health needs and care of school-age children.

7. The Boards of the Departments of Education and Health should establish a formal agreement to meet jointly at a minimum of twice yearly to advise each of the designated agencies on matters pertaining to school health services policy.

8. The Governor's Task Force on indigent care as well as the Secretary of Human Resources should specifically address the special health care needs of the school-age child especially the medically indigent.

9. The Departments of Education, Health, and Mental Health and Mental Retardation should co-sponsor at regular intervals continuing education opportunities for school nursing personnel on a regional basis.

10. The Departments of Health, Education, and Mental Health and Mental Retardation should provide for school personnel continuing education opportunities about the new morbidity facing today's school-age children.

11. Every school division within the state should have a school health advisory body composed of public and private sector representatives to assist with school health policy.

12. An interdisciplinary health care plan for school-age children at the local level should be developed with technical assistance from the State Departments of Education, Health, and Mental Health and Mental Retardation as requested. Such a plan should include a component on methods of financing health care services to school-age children.

13. Each school division within the state should establish formal interagency agreements with appropriate community resources involved in the provision of health care to school-age children. Appropriate community resources may include, but should not be limited to, local health departments, community services boards, social services agencies, institutions of higher education, private sector health professionals, and others.

14. Local school boards should develop, whenever possible, strong relationships with volunteer organizations and the business community for improving the delivery and financing of health care for school-age children.

15. The Virginia Chapter of the American Academy of Pediatrics should encourage its membership to provide a leadership role at the local level in advocating for and providing a coordinated system of health care for school-age children.

16. The Virginia Congress of Parents and Teachers (PTA) and all other parent organizations should vigorously undertake a parent awareness campaign to educate parents about the health needs of school-age children and to increase parental involvement in their children's health.

17. Every school division should establish a cooperative agreement with a physician to serve in the capacity of consulting medical director to provide medical care consultation and backup to nursing personnel.

18. Formal, written emergency medical procedures should be developed in every school division within the state.

19. The State Department of Education should direct all school divisions to maintain appropriate documentation on all student injuries as part of a program of comprehensive risk management.

20. The State Department of Education should continue to monitor and insist that all schools comply with state laws pertaining to vision and hearing assessments.

21. The Department of Education should direct all school divisions to provide time in the curriculum for health education. Further, there should be a strong emphasis on health promotion and disease and injury prevention programs.

22. The Department of Education should assist all school divisions with guidance on the physical education curriculum to develop and emphasize individual fitness programs.

23. The Department of Education should encourage all school divisions to establish after school programs addressing health issues and concerns.

HOUSE DOCUMENT NO. 19, 1989

A STUDY ON WAYS TO ENCOURAGE LOCAL SCHOOL DIVISIONS TO RECOGNIZE THE IMPORTANCE OF SCHOOL NURSES AND THE FEASIBILITY OF ESTABLISHING STANDARDS FOR SCHOOL HEALTH SERVICES

Recommendations

The Department of Education, in cooperation with the Department of Health, was requested by the 1988 General Assembly of Virginia to study ways to encourage local school divisions to recognize the importance of school nurses and the feasibility of establishing standards for health services in the public schools in the Commonwealth (House Joint Resolution Number 33 ({HJR 33})). A study committee was established to respond to the task as defined by HJR 33.

Based on the study committee's research and formal discussions, the following recommendations are offered as ways to encourage local school divisions to recognize the importance of school nurses and the feasibility of standards for school health services:

1. Qualified school nurses should be required in every school division contingent upon appropriate funding.
2. The goal for nurse/student ratios should conform to the standards set by the National Association of School Nurses, American Nurses Association, and the American School Health Association.
3. School health advisory boards, composed of public and private sector representatives, should be established to enhance community support for school health services and to assist in the development of local school health policy.
4. Minimum standards for school health services in Virginia should be developed jointly by the Departments of Education and Health.
5. A nursing position should be established by the Departments of Education and Health within their respective departments to supervise and coordinate the provision of school health services.
6. School nurses should be involved as members of school teams to facilitate learning by providing care and treatment to students with chronic and handicapping conditions.

7. Students and school personnel should be counselled as a means of reducing the "new morbidities."

8. A cooperative agreement should be established in every school division with a physician to serve in the capacity of consulting medical director to provide medical care, consultation, and backup to nursing personnel.

9. Formal written emergency medical procedures should be developed in every school division within the state.

10. Appropriate documentation on all student injuries should be maintained by all school divisions as part of a program of comprehensive risk management.

11. Continuing education opportunities, especially in the new morbidities, should be co-sponsored by the Departments of Education, Health, Mental Health and Mental Retardation on a regional basis, and at regular intervals for school nursing personnel.

12. Qualifications for school nurses should be developed jointly by the Departments of Education and Health.

Appendix C-1

SCHOOL NURSE PERFORMANCE EVALUATION

(For Use By School Nurse Administrator)

Name ______________________________ SSN ____________

School Year ____________

Date of Evaluation ____________

Documentation provided as appropriate ☐ Yes ☐ No

EVALUATION ATTRIBUTES	Superior Performance	Above Expectation	At Expectation	Needs Improvement	Unsatisfactory Performance
	5	4	3	2	1
Standard I — Theory THE SCHOOL NURSE APPLIES APPROPRIATE THEORY AS BASIS FOR DECISION MAKING IN NURSING PRACTICE. COMMENTS:					
Standard II — Program Management THE SCHOOL NURSE ESTABLISHES AND MAINTAINS A COMPREHENSIVE SCHOOL HEALTH PROGRAM. COMMENTS:					
Standard III — Nursing Process **THE SCHOOL NURSE COLLECTS INFORMATION ABOUT THE HEALTH AND DEVELOPMENTAL STATUS OF THE STUDENT IN A SYSTEMATIC AND CONTINUOUS MANNER.** COMMENTS:					
THE SCHOOL NURSE USES DATA COLLECTED ABOUT THE HEALTH AND DEVELOPMENTAL STATUS OF THE STUDENT TO DETERMINE A NURSING DIAGNOSIS. COMMENTS:					

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Name: ______________________________

	Superior Performance	Above Expectation	At Expectation	Needs Improvement	Unsatisfactory Performance
	5	4	3	2	
Standard III — Nursing Process (Continued)					
THE SCHOOL NURSE DEVELOPS A NURSING CARE PLAN WITH SPECIFIC GOALS AND INTERVENTIONS DELINEATING SCHOOL NURSING ACTIONS UNIQUE TO STUDENTS NEEDS. COMMENTS:					
THE SCHOOL NURSE INTERVENES AS GUIDED BY THE NURSING CARE PLAN TO IMPLEMENT NURSING ACTIONS THAT PROMOTE, MAINTAIN, OR RESTORE HEALTH, PREVENT ILLNESS, AND AFFECT REHABILITATION. COMMENTS:					
THE SCHOOL NURSE ASSESSES STUDENT RESPONSES TO NURSING ACTIONS IN ORDER TO REVISE THE DATA BASE, NURSING DIAGNOSIS, AND NURSING CARE PLAN, AND TO DETERMINE PROGRESS MADE TOWARD GOAL ACHIEVEMENT. COMMENTS:					
Standard IV — Interdisciplinary Collaboration					
THE SCHOOL NURSE COLLABORATES WITH OTHER PROFESSIONALS IN ASSESSING, PLANNING, IMPLEMENTING, AND EVALUATING PROGRAMS AND OTHER SCHOOL HEALTH ACTIVITIES. COMMENTS:					
Standard V — Health Education					
THE SCHOOL NURSE ASSISTS STUDENTS, FAMILIES, AND GROUPS TO ACHIEVE OPTIMAL LEVELS OF WELLNESS THROUGH HEALTH EDUCATION. COMMENTS:					

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Name: ______________________________

Standard VI — Professional Development

THE SCHOOL NURSE PARTICIPATES IN EVALUATION TO ENSURE QUALITY OF HEALTH SERVICES PROVIDED FOR STUDENTS AND ASSUMES RESPONSIBILITY FOR CONTINUING EDUCATION AND PROFESSIONAL DEVELOPMENT OF SELF AND PEERS.

COMMENTS:

Standard VII — Community Health Systems

THE SCHOOL NURSE ASSISTS THE HEALTH SERVICE COORDINATOR TO ASSESS, PLAN, IMPLEMENT, AND EVALUATE SCHOOL HEALTH SERVICES IN THE BROAD CONTINUUM OF PROMOTION OF PRIMARY, SECONDARY, AND TERTIARY PREVENTION.

COMMENTS:

Standard VIII — Research

THE SCHOOL NURSE CONTRIBUTES TO NURSING AND SCHOOL HEALTH THROUGH INNOVATIONS IN THEORY AND PRACTICE AND PARTICIPATION IN RESEARCH.

COMMENTS:

Superior Performance	Above Expectation	At Expectation	Needs Improvement	Unsatisfactory Performance
5	4	3	2	1

EVALUATION SUMMARY

COMMENTS:

Total Possible Score ________

Nurse's Score This Rating ________

____

Health Services Coordinator Date

COMMENTS:

____

School Nurse Date

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SCHOOL NURSE PERFORMANCE EVALUATION DATA INPUT/SITE ADMINISTRATORS

Name (For Use By Non-Nurse Administrator) SSN ________

School ________

School Year ________

Signature of Administrator and Date ________

	Superior Performance	Above Expectation	At Expectation	Needs Improvement	Unsatisfactory Performance
The School Nurse —	5	4	3	2	1
Program Management Exhibits leadership in the establishment and maintenance of school health programs which meet existing needs and identifies future needs of the student, school, and community.					
Interdisciplinary Collaboration Collaborates with other professionals in assessing, planning, implementing, and evaluating programs and activities to benefit students.					
Health Education Demonstrates competency in the development, promotion, and implementation of health education activities.					
Professional Development Participates in continuing professional education. Serves as a resource for or provider of staff development activities.					
Community Health Works effectively with individuals, public and private agencies and other community groups. Utilizes community resources to meet student health needs.					
Policies, Statutes, and Regulations Understands and complies with school site and district policy and procedures, and state statutes and regulations.					

Comments:

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SCHOOL NURSE PERFORMANCE EVALUATION

Name ______________________________ SSN ______________

☐ Interim Conference ______________ ☐ Summary Conference ______________

Rating Score Rating Score

COMMENTS:

______________________________ ______________________________

Administrator Title Date

COMMENTS:

______________________________ ______________________________

School Nurse Date

Appendix D-1

GROWTH CHARTS WITH REFERENCE PERCENTILES FOR BOYS 2 TO 18 YEARS OF AGE

Stature for Age
Weight for Age
Weight for Stature

NAME ______________________ RECORD # ______________________

DATE OF BIRTH ______________________

Date of Measurement	Age		Stature	Weight		
	Years	Months				

These charts to record the growth of the individual child were constructed by the National Center for Health Statistics in collaboration with the Center for Disease Control. The charts are based on data from national probability samples representative of boys in the general U.S. population. Their use will direct attention to unusual body size which may be due to disease or poor nutrition.

Measuring: Take all measurements with the child in minimal indoor clothing and without shoes. Measure stature with the child standing. Use a beam balance to measure weight.

Recording: First take all measurements and record them on this front page. Then graph each measurement on the appropriate chart. Find the child's age on the horizontal scale; then follow a vertical line from that point to the horizontal level of the child's measurement (stature or weight). Where the two lines intersect, make a cross mark with a pencil. In graphing weight for stature, place the cross mark directly above the child's stature at the horizontal level of his weight. When the child is measured again, join the new set of cross marks to the previous set by straight lines.

Do not use the weight for stature chart for boys who have begun to develop secondary sex characteristics.

Interpreting: Many factors influence growth. Therefore, growth data cannot be used alone to diagnose disease, but they do allow you to identify some unusual children.

Each chart contains a series of curved lines numbered to show selected percentiles. These refer to the rank of a measure in a group of 100. Thus, when a cross mark is on the 95th percentile line of weight for age it means that only five children among 100 of the corresponding age and sex have weights greater than that recorded.

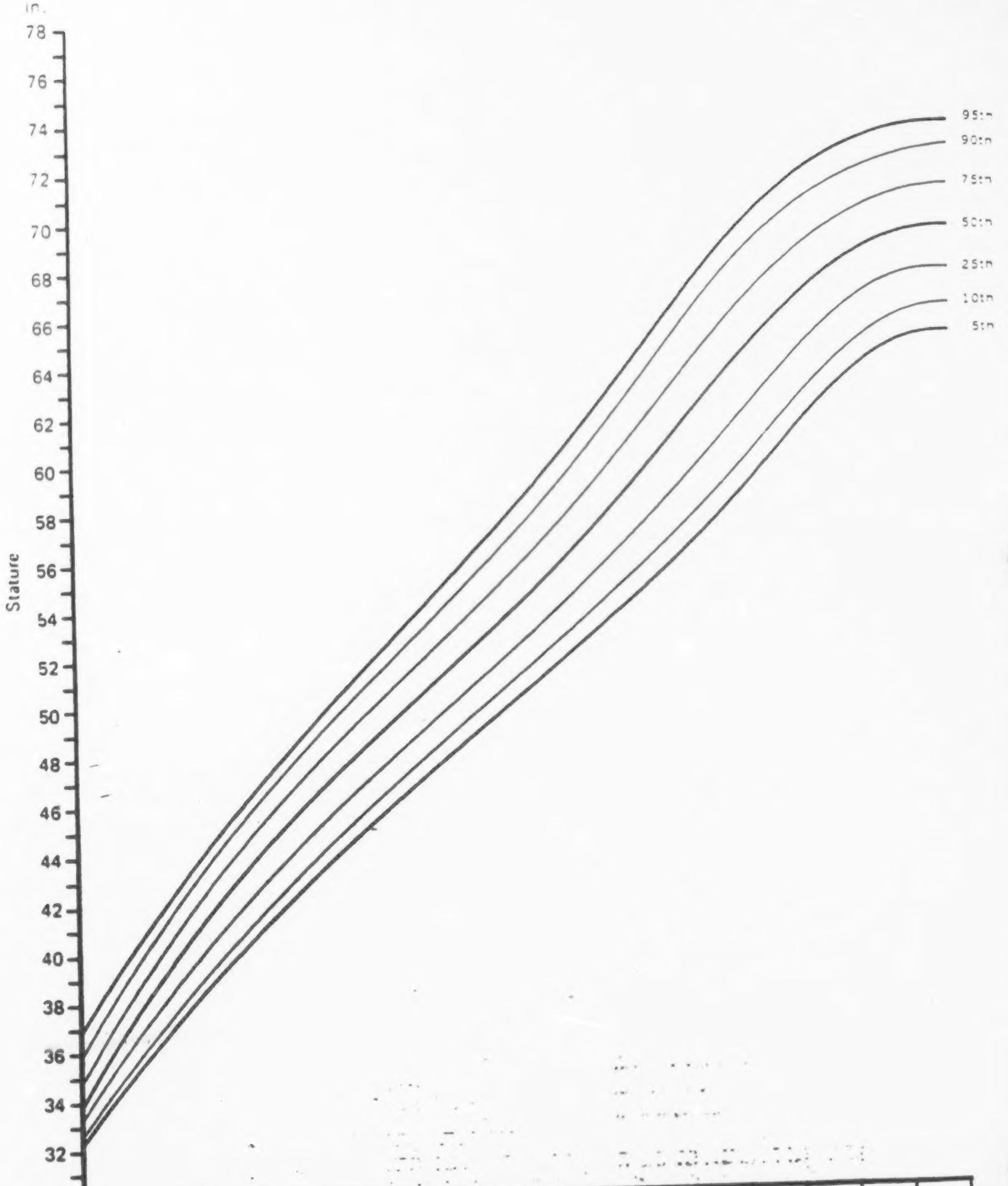
Inspect the set of cross marks you have just made. If any are particularly high or low (for example, above the 95th percentile or below the 5th percentile), you may want to refer the child to a physician. *Compare* the most recent set of cross marks with earlier sets for the same child. If he has changed rapidly in percentile levels, you may want to refer him to a physician. Rapid changes are less likely to be significant when they occur within the range from the 25th to the 75th percentile.

In normal teenagers, the age at onset of puberty varies. Rises occur in percentile levels if puberty is early, and these levels fall if puberty is late.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION, NATIONAL CENTER FOR HEALTH STATISTICS, AND CENTER FOR DISEASE CONTROL

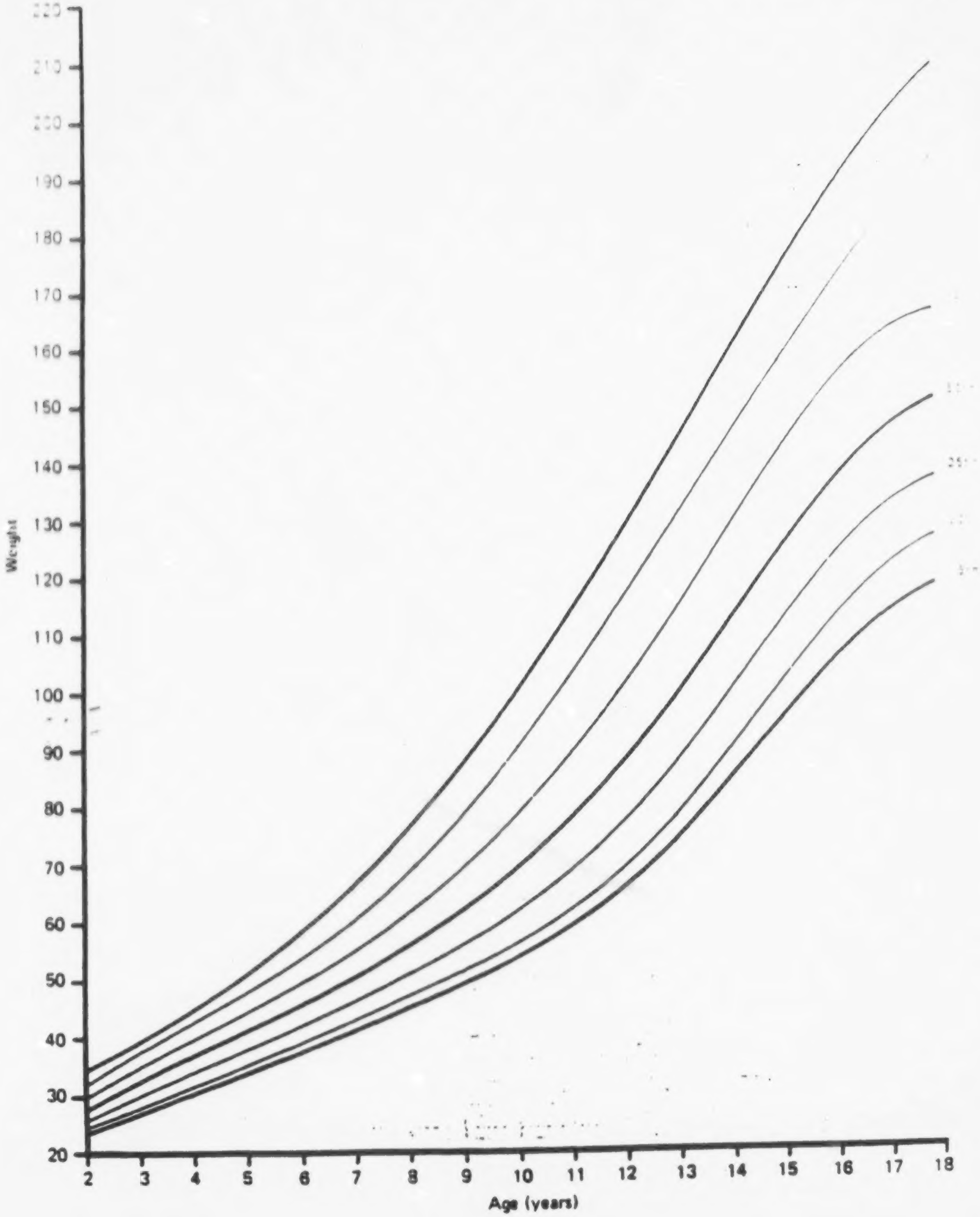
BOYS FROM 2 TO 18 YEARS

STATURE FOR AGE



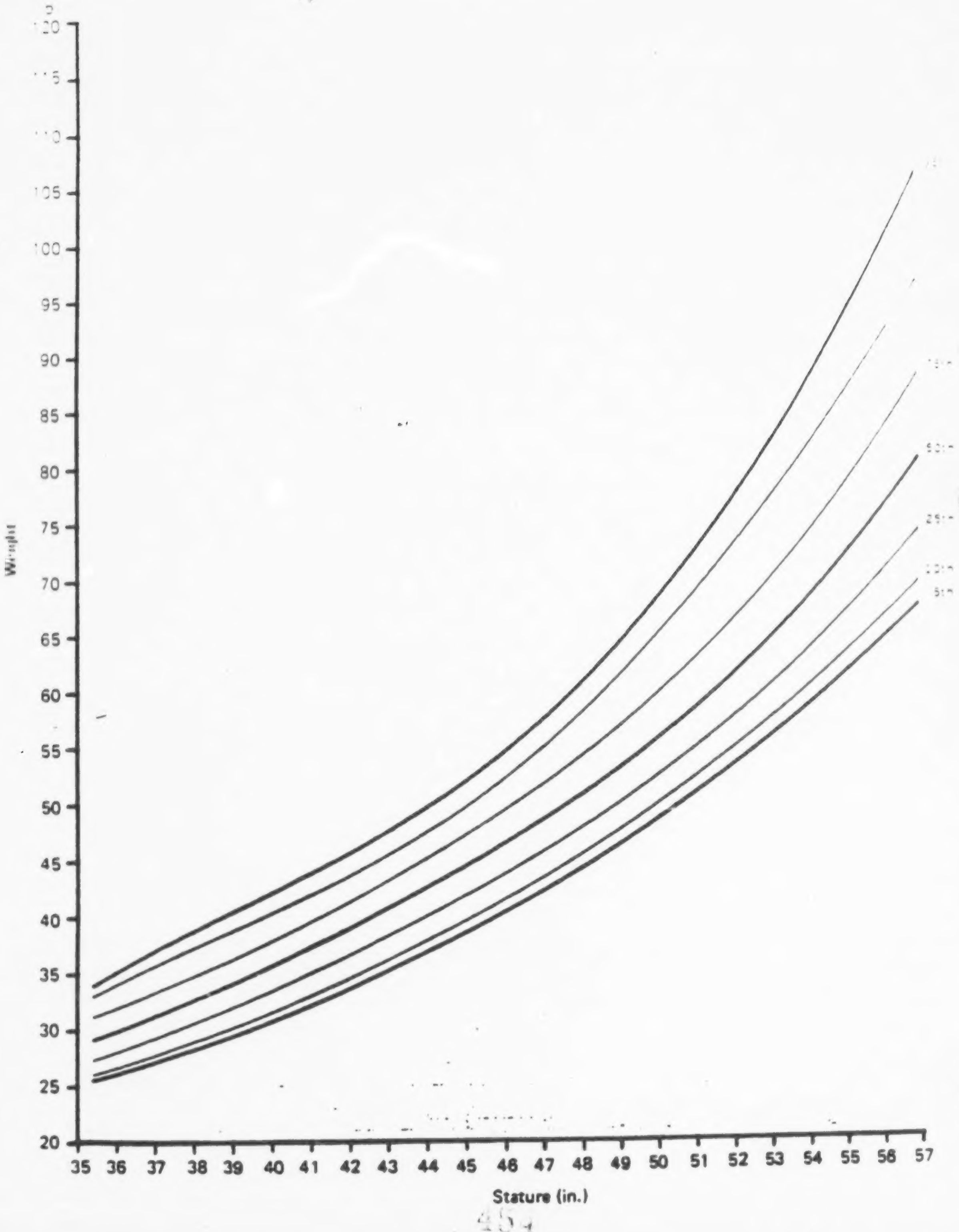
BOYS FROM 2 TO 18 YEARS

WEIGHT FOR AGE



PRE-PUBERTAL BOYS FROM 2 TO 11½ YEARS

WEIGHT FOR STATURE



Appendix D-2

GROWTH CHARTS
WITH REFERENCE PERCENTILES
FOR GIRLS
2 TO 18 YEARS OF AGE

Stature for Age
Weight for Age
Weight for Stature

NAME ____________________ RECORD # ____________________

DATE OF BIRTH ____________________

Date of Measurement	Age		Stature	Weight		
	Years	Months				

These charts to record the growth of the individual child were constructed by the National Center for Health Statistics in collaboration with the Center for Disease Control. The charts are based on data from national probability samples representative of girls in the general U.S. population. Their use will direct attention to unusual body size which may be due to disease or poor nutrition.

Measuring: Take all measurements with the child in minimal indoor clothing and without shoes. Measure stature with the child standing. Use a beam balance to measure weight.

Recording: First take all measurements and record them on this front page. Then graph each measurement on the appropriate chart. Find the child's age on the horizontal scale; then follow a vertical line from that point to the horizontal level of the child's measurement (stature or weight). Where the two lines intersect, make a cross mark with a pencil. In graphing weight for stature, place the cross mark directly above the child's stature at the horizontal level of her weight. When the child is measured again, join the new set of cross marks to the previous set by straight lines.

Do not use the weight for stature chart for girls who have begun to develop secondary sex characteristics.

Interpreting: Many factors influence growth. Therefore, growth data cannot be used alone to diagnose disease, but they do allow you to identify some unusual children.

Each chart contains a series of curved lines numbered to show selected percentiles. These refer to the rank of a measure in a group of 100. Thus, when a cross mark is on the 95th percentile line of weight for age it means that only five children among 100 of the corresponding age and sex have weights greater than that recorded.

Inspect the set of cross marks you have just made. If any are particularly high or low (for example, above the 95th percentile or below the 5th percentile), you may want to refer the child to a physician. *Compare* the most recent set of cross marks with earlier sets for the same child. If she has changed rapidly in percentile levels, you may want to refer her to a physician. Rapid changes are less likely to be significant when they occur within the range from the 25th to the 75th percentile.

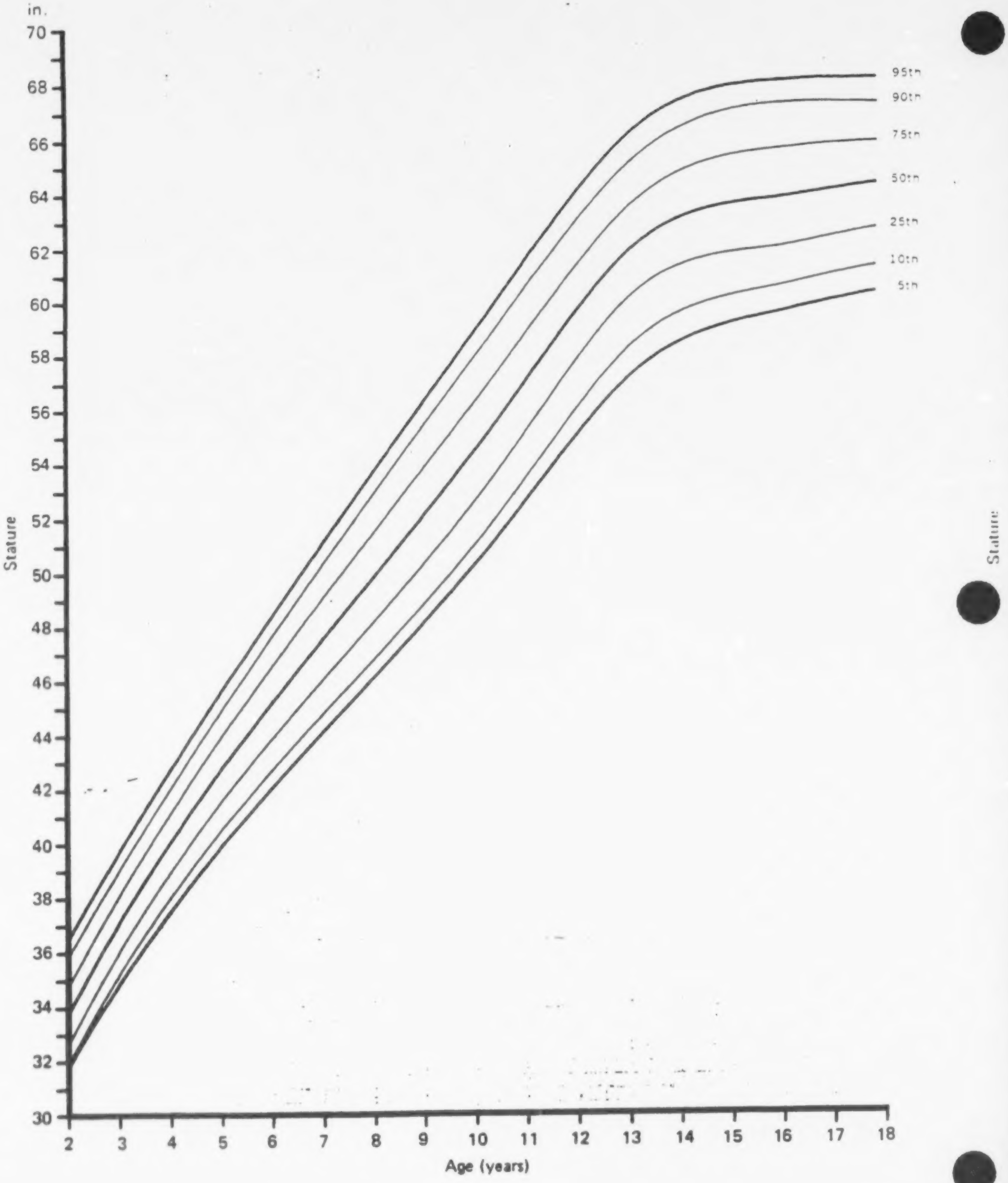
In normal teenagers, the age at onset of puberty varies. Rises occur in percentile levels if puberty is early, and these levels fall if puberty is late.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION, NATIONAL CENTER FOR HEALTH STATISTICS, AND CENTER FOR DISEASE CONTROL

MCH-220 (10/86)

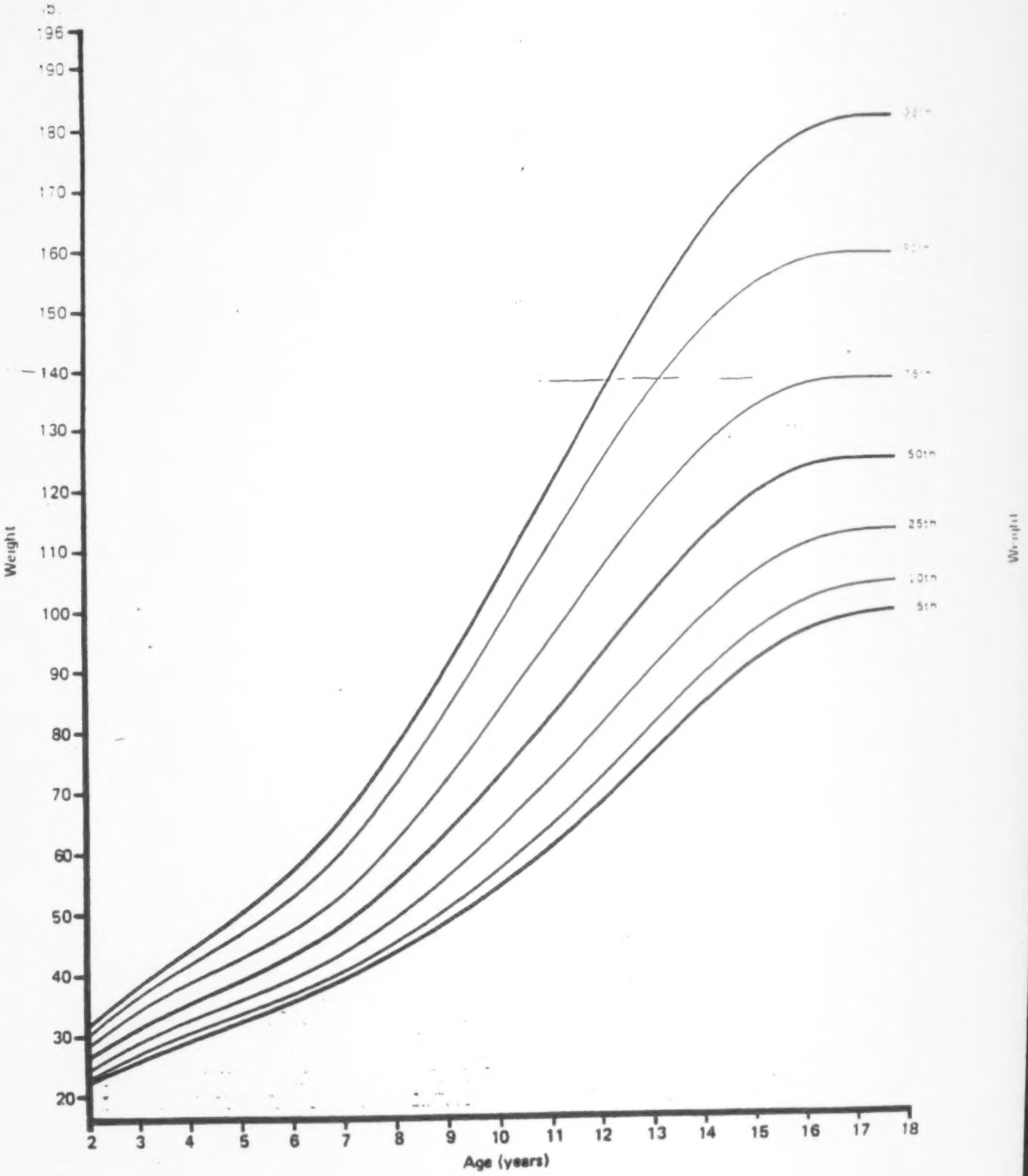
GIRLS FROM 2 TO 18 YEARS

STATURE FOR AGE



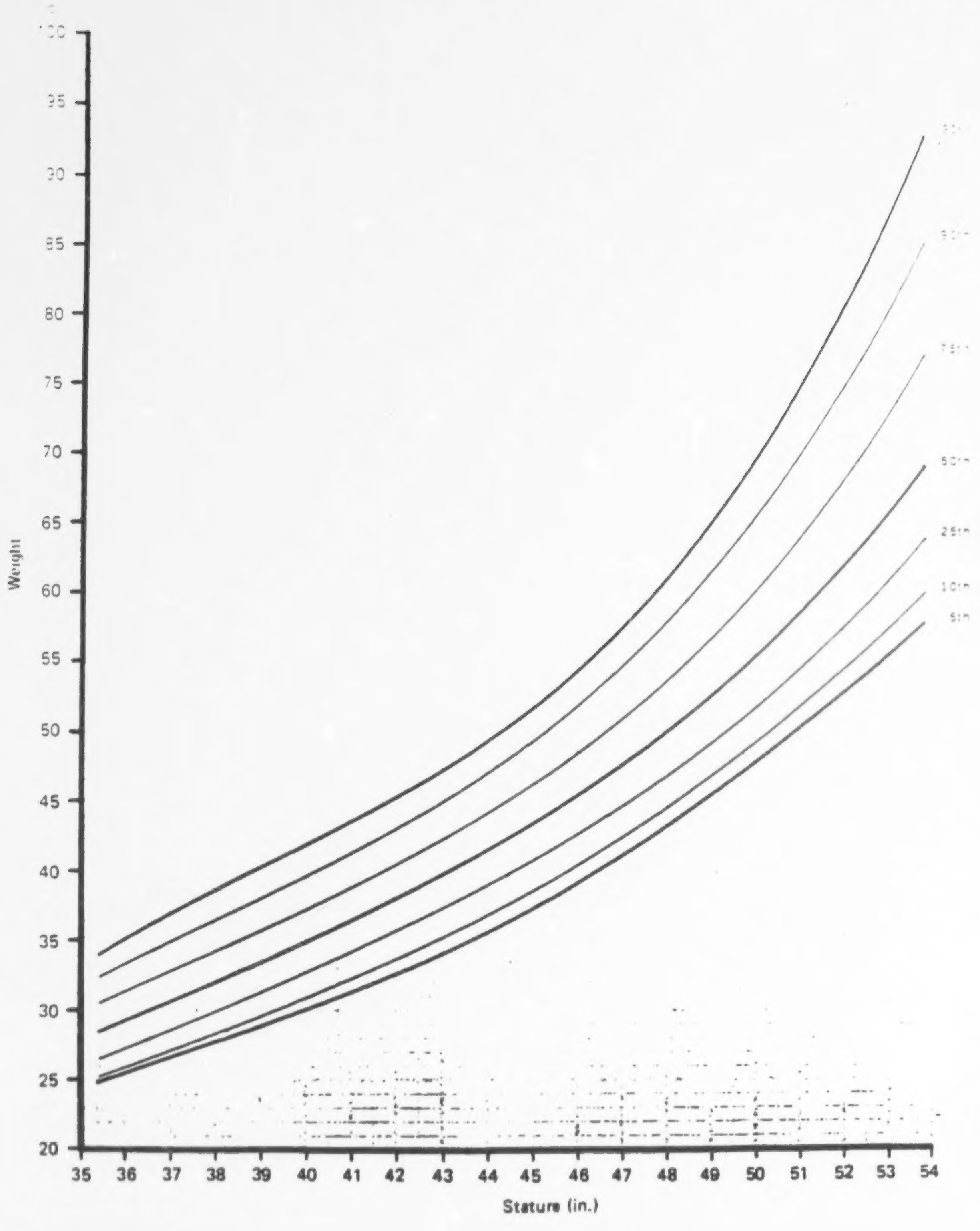
GIRLS FROM 2 TO 18 YEARS

WEIGHT FOR AGE



PRE-PUBERTAL GIRLS FROM 2 TO 10 YEARS

WEIGHT FOR STATURE



COMMUNICABLE DISEASE REFERENCE CHART FOR SCHOOL PERSONNEL

DISEASE	INCUBATION PERIOD	COMMON SIGNS AND SYMPTOMS	RECOMMENDATIONS
Chickenpox (Varicella)	From 2 to 3 weeks, usually 13 to 17 days.	Sudden onset with slight fever and itchy eruptions which become vesicular (small blisters) within a few hours. Lesions commonly occur in successive crops, with several stages of maturity present at the same time.	Communicable for as long as 5 days before eruption of vesicles and for not more than 5 days after the appearance of the first crop of vesicles. CASE: Exclude from school for at least 6 days after eruption first appears or until vesicles become dry. Avoid exposure to women in early pregnancy who have not had chickenpox. CONTACTS: On appearance of first sign or symptom, exclude from school for 7 days.
Cryptosporidiosis	From 2 to 14 days.	Watery diarrhea and low grade fever	CASE: Exclude until cessation of diarrhea. CONTACTS: School exclusion not indicated.
Fifth Disease (Erythema Infectiosum)	From 4 to 20 days.	Mild illness without fever. Rash characterized by a vivid reddening of the skin especially of the face which fades and recurs; classically, described as a "slapped cheek appearance."	CASE: Exclusion from school not required. CONTACTS: School exclusion not indicated.
German Measles (Rubella)	From 14 to 23 days, usually 16 to 18 days.	Mild symptoms; slight fever, rash of variable character lasting about 3 days; enlarged head and neck lymph glands common. Joint pain may occur especially in older children and adults.	Communicable for 7 days before onset of rash and at least 4 days thereafter. CASE: Exclude from school for 7 days after onset of rash. Avoid exposure to women in early pregnancy. Check immunization records. CONTACTS: Those who are pregnant and not immunized should be urged to seek medical advice.
Giardiasis	From 1 to 4 weeks.	Frequently asymptomatic, but may have diarrhea.	CASE: Exclude until cessation of diarrhea. Exclusion of asymptomatic carriers of giardia is not recommended. CONTACTS: School exclusion not indicated.
Hepatitis A (Infectious Hepatitis)	From 15 to 50 days, usually 28 days.	Fever, loss of appetite, nausea, abdominal discomfort and weakness followed by jaundice. Many unrecognized mild cases without jaundice occur, especially in children.	Communicability greatest from 7 days before to several days after onset of jaundice. CASE: Exclude from school until physician advises return. Convalescence may be prolonged. CONTACTS: School exclusion not indicated.
Human Immunodeficiency Virus Infection	Variable	A broad range of disease manifestations affecting multiple organ systems. Many children remain asymptomatic.	CASE: Follow advice of child's physician and/or the local health department. CONTACTS: School exclusion not indicated.

Impetigo Contagiosa	Unknown	Multiple skin lesions usually of exposed areas (e.g., elbows, legs and knees), but may involve any area. Lesions vary in size and shape, and begin as blisters which rapidly mature into brown crusts on a reddened base. Healing from center outward produces circular areas which may resemble ringworm.	CASE: Exclude from school until physician advises return (usually 1 day). CONTACTS: Exclusion from school not indicated. Observe carefully for symptoms.
Measles (Rubeola, Red Measles)	From 8 to 13 days, usually 10 days.	Prodrome characterized by fever followed by reddened eyes, runny nose, and cough. Dusky-red blotchy rash appears on day 3 or 4 and lasts 4 to 7 days.	Communicable from beginning of prodromal period to 4 days after appearance of the rash. CASE: Exclude from school until at least 4 days after appearance of the rash. CONTACTS: Check immunization records. Exclude from school immediately on signs of prodrome.
Meningitis, Haemophilus	Unknown, probably 2 to 4 days.	Sudden onset of fever, vomiting, lethargy and stiff neck. Progressive stupor or coma are common.	CASE: Exclude from school until physician advises return. CONTACTS: School exclusion not indicated. Observe carefully for symptoms, especially fever. Parents of day care/nursery school contacts should be advised to check with their childrens' physicians concerning prophylactic treatment with rifampin. Discuss problem with local health department.
Meningitis, Meningococcal	From 1 to 10 days, usually 3 to 4 days.	Sudden onset of fever and intense headache. Delirium and coma often appear early; a characteristic (measles-like) rash usually follows. Can be fatal despite prompt diagnosis and treatment.	CASE: Exclude from school during acute illness. (Non-communicable after 24 hours of appropriate drug therapy.) CONTACTS: School exclusion not indicated. Parents of day care contacts should be urged to seek their physicians' advice concerning prophylactic treatment with rifampin. Discuss problem with local health department.
Mumps (Infectious Parotitis)	From 2 to 3 weeks, usually 18 days.	Fever with swelling and tenderness of one or both parotid glands located below and in front of the ears. Unrecognized mild cases without swelling may occur.	Communicable from 6 days before swelling until 9 days after. CASE: Exclude from school for 9 days after the onset of parotid gland swelling. CONTACTS: School exclusion not indicated.
Pediculosis (Lice)	Under optimum conditions, eggs hatch in 7 days and reach maturity in about 10 days.	Severe itching and scratching, often with secondary infection. Scalp and hairy portions of body may be affected. Eggs of head lice (nits) attach to hairs as small, round, gray lumps.	CASE: Exclude from school until treated by a physician. CONTACTS: Direct inspection of head, body, and clothing recommended. School exclusion not indicated in absence of infestation.
Rotavirus Infections	Usually 1 to 3 days.	Diarrhea, usually preceded by vomiting and low-grade fever. May also be accompanied by cough.	CASE: Exclude from school until cessation of diarrhea. CONTACTS: School exclusion not indicated.

Salmonellosis	From 6 to 72 hours, usually 12 to 36 hours.	Sudden onset of fever, abdominal pain, diarrhea, nausea, and frequent vomiting. Dangerous dehydration may occur in younger children.	Stools usually positive for Salmonella for several days to several weeks; a few patients test positive for several months. CASE: Exclude from school until physician advises return. CONTACTS: School exclusion and stool cultures not indicated in absence of symptoms.
Scabies	From 2 to 6 weeks.	Begins as itchy raised areas or burrows around finger webs, wrists, elbows, armpits, belt-line, and/or genitalia. Extensive scratching often results in secondary infection.	CASE: Exclude from school until physician advises return. CONTACTS: Direct inspection of body. School exclusion not indicated in absence of infestation.
Scarlet Fever	Usually 1 to 3 days, rarely longer.	Fever, sore throat, exudative tonsillitis or pharyngitis. Rash appears most often on neck, chest, and skin folds of arms, elbows, groin and inner aspect of thighs.	CASE: Exclude from school during acute illness. Non-communicable after 24 hours of appropriate drug therapy. CONTACTS: Exclude from school on appearance of signs or symptoms. Culturing of school contacts and treatment of carriers not usually indicated.
Shigellosis (Bacillary Dysentery)	From 1 to 7 days, usually 3 days.	Diarrhea, fever and often vomiting and cramps. In severe cases the stools may contain blood.	CASE: Exclude from school until cessation of diarrhea. CONTACTS: School exclusion not indicated. Stool cultures indicated only in suspected school outbreaks.
Tinea Corporis (Ringworm of the Body)	From 4 to 10 days.	Circular well-demarcated lesion that can involve face, trunk or limbs. Pruritus is common.	CASE: Exclusion from school not indicated as long as lesions are covered or child is being treated by a physician. CONTACTS: School exclusion not indicated.
Whooping Cough (Pertussis)	Usually 7 days, almost uniformly within 10 days, and rarely exceeding 14 days.	Catarrhal stage begins with upper respiratory symptoms and increasingly irritating cough. The paroxysmal stage usually follows within 1 to 2 weeks, and lasts 1 to 2 months. Paroxysmal stage is characterized by repeated episodes of violent cough broken by a high-pitched inspiratory whoop. Older children may not have whoop. Convalescence may require many weeks.	CASE: Exclude from school until a physician advises return (usually 5 days after initiation of erythromycin therapy). CONTACTS: Check immunization records. Exclude on first sign or symptom.

NOTE: A more complete discussion of these conditions and other communicable diseases may be found in Control of Communicable Diseases in Man (1990) published by the American Public Health Association. Additional information and consultation are also available through your local health department. VIRGINIA DEPARTMENT OF HEALTH, OFFICE OF EPIDEMIOLOGY, P.O. BOX 2448, RICHMOND, VIRGINIA 23218.

REV:02/92

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Appendix F

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
P. O. BOX 6Q
RICHMOND, VIRGINIA 23216-2060

SUPTS. MEMO. NO. 61
June 12, 1992

ADMINISTRATIVE

TO: Division Superintendents

FROM: Joseph A. Spagnolo, Jr.
Superintendent of Public Instruction

Ernest W. Martin
Executive Assistant to the Superintendent

SUBJECT: Student Health

The attached memo was prepared jointly by Secretary Dyke, State Board president James P. Jones, and Dr. Spagnolo. The memo is designed to focus attention on student health issues and your thoughtful review and response is appreciated.

An additional Supts. Memo is being prepared which provides more complete information on the requirement that each local school board establish a School Health Advisory Council.

Thank you for your attention to this matter.

JASJr/EWM/pg

Enclosure

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COMMONWEALTH of VIRGINIA

James W. Dyke, Jr
Secretary of Education

Office of the Governor
Richmond 23219

(804) 786-[illegible]
TDD (804) 786-[illegible]

MEMORANDUM June 9, 1992

TO: ALL LOCAL SUPERINTENDENTS

ALL LOCAL SCHOOL BOARD CHAIRS

FROM: James W. Dyke, Jr.
James P. Jones, President, Board of Education
Joseph A. Spagnolo, Jr., Superintendent of Public Instruction

SUBJECT: Student Health Issues

In all of our discussions about educational goals, we have made it clear that in order for students to take full advantage of a "world class education," they must be ready to learn when they enter school and be healthy so they can concentrate on learning while they are in school.

In that regard, the Governor's Task Force on Child Health recommended that the Secretaries of Education and Health and Human Resources work together to encourage local school divisions to increase the school's role in improving the health of our children.

Secretary Dyke and Secretary of Health and Human Resources Howard Cullum have moved to implement that recommendation by agreeing that certain actions should be taken by each school division in Virginia. The purpose of this memorandum is to request that your division work to enact the following actions by the beginning of the 1992-93 school year:

1. All school divisions should take advantage of the federally-funded school breakfast program or a comparable program. Students cannot learn if they are hungry. This program offers students an opportunity to receive needed nourishment to give them energy during the school day. The program is funded by the federal government and it should be

used by every school in Virginia. The Department of Education is prepared to assist localities that do not presently offer this program to have such a program in place by the start of the next school year.

2. School divisions should work towards having on-site health screening for children. Many children presently do not have access to health care. One way we are addressing this need is by our planning for pilot school-Community Health Clinics, funded through Medicaid. We encourage your individual efforts to make health screenings available, and we encourage you to work with us on our Medicaid pilot programs. In addition, consideration should be given to involvement with the federal Early and Periodic Screening, Diagnosis and Treatment Program, which supports screening and early intervention.

3. School buildings should be "smoke free" as well as "drug free." Smoking in school buildings should be banned (or at least confined to a separate designated area). Treatment alternatives for those persons making the transition from smoking to non-smoking should be publicized.

4. School divisions should make available to students and their families information about locally available health services.

5. Schools should make every effort to have a medical staff person available to each building during school hours. This can be accomplished through creative approaches, including working with local businesses and medical organizations in a public/private partnership.

6. All school divisions should have in place by December 1992 the Health Advisory Councils required by the Code of Virginia § 22.1-275.1 and revised in Senate Bill 435. Further, these councils should be fully utilized to help develop community support for the health initiatives

schools need to implement in order to fully serve our students.

7. Review school food policies for the purpose of eliminating unhealthy junk food and promoting the availability of nutritious, healthy food items. This applies to school cafeteria or food sales as well as vending machines which are accessible to students.

8. Review physical education policies to ensure that each student, from preschool to secondary school, participates in an appropriate and meaningful program geared toward physical fitness.

9. In recognition of the health, injury, and developmental problems associated with contact sports, the Governor's Task Force on Intercollegiate Athletics will be reviewing the appropriate age for students to begin involvement in interscholastic athletics. Superintendents should pay particular attention to the work of this task force in their review of the elementary and secondary school athletics.

We realize that school systems have full plates in terms of meeting standards and accomplishing goals, particularly in tight economic times. We also, however, agree that we cannot afford to ignore the health needs of our students. Achieving world class education requires students ready to learn and that means healthy students. We and the Department stand ready to work with you to implement these initiatives.

JWDJr/JPJ/JASJr/pfc

cc: The Honorable Howard M. Cullum

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